

Hal H. Kimowitz, DMD, PA

75 Bloomfield Avenue

Suite 205

Denville NJ 07834

(973)627-3363



Patient Information

Chart #.

FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

Whom may we thank for referring you to our practice?

- Dental Office Yellow Pages Internet Newspaper
 School Work Other (name below):

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

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Primary Dental Insurance:

Name of Insured:

Last

First

MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City

State

Zip Code

Insured's Employer Name:

Employer Address:

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City

State

Zip Code

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Secondary Dental Insurance:

Relationship to Patient:

Name of Insured:

Last

First

MI

Insured's Birth Date:

ID #.

Group #.

Insured's Address:

City

State

Zip Code

Insured's Employer Name:

Employer Address:

City

State

Zip Code

Patient's relationship to insured:

Self

Spouse

Child

Other

Insurance Plan Name:

Insurance Address:

City

State

Zip Code

Response Date:

Have you had any of the following diseases or medical problems?

- | | |
|--|----------------------------------|
| Y N Anemia/Radiation Treatment | Y N Heart Surgery/Pacemaker |
| Y N Artificial Bones/Joint Replacement | Y N Hemophilia/Abnormal Bleeding |
| Y N Asthma/Arthritis | Y N Hepatitis |
| Y N Artificial Valves | Y N High/Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+/AIDS |
| Y N Cancer/Chemotherapy | Y N Hospitalized for any reason |
| Y N Congenital Heart Defect | Y N Kidney Problems |
| Y N Diabetes/Tuberculosis(TB) | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug/Alcohol Abuse | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema/Glaucoma | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Shingles |
| Y N Fever Blisters/Herpes | Y N Sinus Problems |
| Y N Heart Attack/Stroke | Y N Ulcers/Colitis |
| Y N Heart Murmur | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Please list all medications you are taking:

Are you allergic to any of the following?

- | | | |
|------------------------|------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Other |
| Y N Dental Anesthetics | Y N Penicillin | |

Please list any other drugs that you are allergic to:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductions that my insurance does not cover.

Signature

Date

Thank you for filling out the forms completely. It will enable us to help you more effectively. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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Medical & Dental History Form

Patient Name:
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

Yes No

Within the past year, have there been any changes in your general health?

Yes No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Are you currently taking any prescription or non-prescription medications?
- Do you use tobacco (smoking or chewing)?
- Do you require the use of corrective lenses (contacts or glasses)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:



WOMEN ONLY: Are you pregnant?

Yes No

Please indicate if you have experienced any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> *PreMed Amox | <input type="checkbox"/> *PreMed Biaxin | <input type="checkbox"/> *PreMed Clinda | <input type="checkbox"/> *PreMed Keflex |
| <input type="checkbox"/> *PreMed Other | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Carbo Only | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No EPI | <input type="checkbox"/> O2 w/ Xylo | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> See Notes | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Do you have any other health issues or allergies?

Please list all of the medications you are currently taking:

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What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

- 3 (+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

- 1 (+) a day 2 - 6 weekly 1 - 6 monthly Seldom Never

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
 Do your teeth experience sensitivity to cold or hot temperatures?
 Are any of your teeth currently causing you pain?
 Do you grind your teeth (either consciously or during sleep)?
 Are any of your teeth loose, or are you concerned about any teeth loosening?
 Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

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If you could change anything about your mouth, teeth, or smile, what would it be?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____

Date:

Relationship to Patient:

Response Date: