

# Pascack Dental Arts

Date / /

## PATIENT INFORMATION

|  |  |                                       |                                |
|--|--|---------------------------------------|--------------------------------|
| Patient's Name   |  | Home Phone<br>( )                     | Work Phone<br>( )              |
| Street Address   |  | City                                  | State      Zip Code            |
| Patient's Date of Birth<br>/ /   | Sex<br>Male <input type="checkbox"/> Female <input type="checkbox"/> | Height                                | Weight      Social Security No |
| Marital Status<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> |  | Occupation                            |                                |
| Purpose of Visit   |  | How Were you Referred to this Office? |                                |

## SPOUSE'S INFORMATION OR GUARDIAN (IF PATIENT IS A MINOR)

|               |                   |                   |
|---------------|-------------------|-------------------|
| Spouse's Name | Home Phone<br>( ) | Work Phone<br>( ) |
|---------------|-------------------|-------------------|

## EMPLOYER'S INFORMATION

|                 |  |      |                     |
|-----------------|--|------|---------------------|
| Employer's Name |  |      |                     |
| Street Address  |  | City | State      Zip Code |

## IN CASE OF EMERGENCY — NEAREST RELATIVE NOT LIVING WITH YOU

|                 |              |                   |                     |
|-----------------|--------------|-------------------|---------------------|
| Relative's Name | Relationship | Home Phone<br>( ) | Work Phone<br>( )   |
| Street Address  |              | City              | State      Zip Code |

## PATIENT'S MEDICAL HEALTH INFORMATION

|  |         |   |                     |
|--|---------|---|---------------------|
| General Health<br>Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> |         | Physician's Name  | Dr's. Phone #       |
| Physician's Street Address   |         | City  | State      Zip Code |
| Date of Last Complete Physical<br>/ /  | Results | Are you Taking Medication Now?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Medication |                     |
| Purpose of Medication  |         |   |                     |

Are you or have you been treated for:

- |                         |                              |                             |                       |                              |                             |                  |                              |                             |
|-------------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|
| Heart Disease           | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Psychiatric Care      | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cancer           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic Fever         | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anemia                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sinus Trouble    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High/Low Blood Pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Glaucoma              | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cough            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Ulcer                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | H.I.V. Positive       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hepatitis        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| TB or Lung Disease      | Yes <input type="checkbox"/> | No <input type="checkbox"/> | A.I.D.S.              | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Arthritis        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Problems        | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Stroke           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Murmur          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Venereal Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Mitral Valve Prolapse | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Nervous Disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|                         |                              |                             | Asthma or Hay Fever   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |                  |                              |                             |

|  |  |  |  |
|--|--|--|--|
| Have you ever had radiation treatment?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain:  |  | Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/><br>How Much?      How Long? |  |
| Are you Allergic to:<br>Penicillin: Yes <input type="checkbox"/> No <input type="checkbox"/> Codeine: Yes <input type="checkbox"/> No <input type="checkbox"/> Local Anesthetics: Yes <input type="checkbox"/> No <input type="checkbox"/> |  | Allergic to Other Medications:   |  |
| Are you subject to prolong bleeding?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | Are you subject to Fainting Spells?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>    |  |
| Do you have excessive urination and/or thirst?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |  |  |
| Have you been hospitalized or had major surgery?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> If yes explain:   |  |  |  |

|                |   |                   |                    |
|----------------|---|-------------------|--------------------|
| <b>WOMEN ▶</b> | Are you Pregnant?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | If Yes, How Long? | Any Complications? |
|----------------|---|-------------------|--------------------|

Do you have any other Medical Conditions you feel we should know?

**DENTAL HISTORY**

Do you have previous dental records or X-ray? ..... Yes \_\_\_ No \_\_\_  
Date of your last visit to a dentist: \_\_\_\_\_  
Last full mouth X-rays were taken when? \_\_\_\_\_  
Are you happy with your smile? If not explain \_\_\_\_\_  
Do you wear dentures? ..... Yes \_\_\_ No \_\_\_  
Do your gums bleed on brushing, flossing or eating? ..... Yes \_\_\_ No \_\_\_  
Do you have a bad taste in your mouth? ..... Yes \_\_\_ No \_\_\_  
Does food catch between your teeth? ..... Yes \_\_\_ No \_\_\_  
Have your teeth shifted? ..... Yes \_\_\_ No \_\_\_  
Are any of your teeth sensitive to heat, cold or pressure? ..... Yes \_\_\_ No \_\_\_  
Do you grind or clench your teeth? ..... Yes \_\_\_ No \_\_\_  
Do you have pain around your ear? ..... Yes \_\_\_ No \_\_\_  
Does your jaw click? ..... Yes \_\_\_ No \_\_\_  
Are there any sores or growths in your mouth? ..... Yes \_\_\_ No \_\_\_  
Do you use a *Water Pik*, dental floss or other device? ..... Yes \_\_\_ No \_\_\_  
Do you wish that your teeth were whiter? ..... Yes \_\_\_ No \_\_\_  
Do you wish that your breath was fresher? ..... Yes \_\_\_ No \_\_\_

I consent to treatment with use of local anesthetic and/or nitrous oxide. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform one of the dentists or hygenists at my next appointment, without fail.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient, Parent, Guardian

\_\_\_\_\_  
Date

**PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:**

Name \_\_\_\_\_ Employer Name \_\_\_\_\_  
Address \_\_\_\_\_ Employer Address \_\_\_\_\_  
Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ SS # \_\_\_\_\_ Work # \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

Name of Insurance: \_\_\_\_\_  
Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB of Insured \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Policy or ID # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

Name of Insurance: \_\_\_\_\_  
Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB of Insured \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Policy or ID # \_\_\_\_\_

**SIGNATURE ON FILE AUTHORIZATION**

- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance carriers
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
- I permit a copy of this authorization to be used in place of the original

Signature of Insured \_\_\_\_\_

Date \_\_\_\_\_