

Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain:

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No Date: _____

Are you taking any medications? Yes No

Please list each one:

Have you ever had any surgical procedures? Yes No

Please list each one:

Nearest relative not living with you:

Name: _____ Relationship: _____

Phone: _____

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.

Signature: _____ Date: _____

Yes No Conditions

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> <input type="checkbox"/> Orthopedic Surgery |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> Heart Stent | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> Shingles |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> <input type="checkbox"/> Colitis | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> <input type="checkbox"/> Slow-Healing Mouth Sores |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | |

Allergies

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Metals | <input type="checkbox"/> Other: _____ |

If Female, Please Answer

Are you taking Birth Control Pills? _____ Are you pregnant? _____ If so, # of Weeks _____ Are you nursing? _____

Dental History

How may we help you today?

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Are you under stress? (new job, moving, etc) Yes No

Do you like your smile? Yes No

If I could change my smile I would: Make them whiter Make them straighter Close spaces

Replace metal fillings with tooth colored restorations Repair chipped teeth Replace missing teeth

Repair crowns that don't match Have a smile makeover

Do your gums bleed? Yes No

How often do you: floss? _____ brush? _____

Are your teeth sensitive to heat, cold or anything else? Yes No

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at **Skylands Dental Care** we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening Veneers Invisalign/ Traditional Orthodontics (Brackets)

Smile Makeover Bonding Partials/Dentures

Sealants Crown and Bridge Implant Crowns

Night/Sport Guards

Skylands Dental Care, P.A.

199 State Rt 284 | Wantage, NJ 07461 | (973) 875-7127

Our Financial Policy

Thank you for choosing Skylands Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Debit, Visa, Mastercard, Discover Card, or American Express
- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care.

- NO INTEREST¹ Payment Plans² from CareCredit
 - o Allow you to pay over time with NO INTEREST¹
 - o Convenient, low monthly payment plans² also available
 - o No annual fees or pre-payment penalties

Please note:

Skylands Dental Care P.A. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We accept payment in thirds for treatments over \$500.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³

Skylands Dental Care, P.A. charges \$35 for returned checks. We also charge a fee for broken (no show) appointments, or appointments that are cancelled with less than 24 hours notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.