



746 Livingston Avenue • North Brunswick, NJ 08902 • (732) 846-8383
495 Plainfield Avenue • Edison, NJ 08817 • (732) 985-1400

Patient Information

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ E-Mail: _____

Phone (Home): _____ Mobil/Cell: _____ (Work): _____ Ext: _____

In case of Emergency, contact: Name _____ Phone _____ Relation _____

Address: _____
Street Apartment #
City State Zip Code

Health Information

Previous Dentist: _____

Date of Last Dental Visit: _____ Date of Last x-rays: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--------------------|---------------------|-----------------------------|--------------------------|
| AIDS | Glaucoma | Lung Disease | Tobacco Usage |
| Allergies _____ | Growths | Mental Disorders | Tuberculosis |
| _____ | Hay Fever | Mitral Valve Prolapse (MVP) | Tumors |
| Anemia | Head Injuries | Nervous Disorders | Ulcers |
| Arthritis | Heart Attack | Pacemaker | Venereal Disease |
| Artificial Joints | Heart Defect | Pregnancy | Antibiotics Allergy |
| Asthma | Heart Disease | Due: _____ | Codeine Allergy |
| Blood Disease | Heart Murmur | Prescribed Weight Loss Med | Latex Allergy |
| Cancer | Hepatitis | Radiation Treatment | Penicillin Allergy |
| Chest Pain | High Blood Pressure | Respiratory Problems | Other Anesthetic Allergy |
| Diabetes | HIV | Rheumatic Fever | |
| Dizziness | Jaundice | Rheumatism | OTHER: _____ |
| Epilepsy | Joint Replacement | Sinus Problems | _____ |
| Excessive Bleeding | Kidney Disease | Stomach Problems | _____ |
| Fainting | Liver Disease | Stroke | _____ |

Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

Are you now under the care of a physician? Yes No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

Are you taking any medications? Please List: _____

What is your primary source of water? Well County
Do you pre-medicate for dental appointments? Yes No If so, why _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Date: _____

Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

What would you like to change the most about the appearance of your teeth? _____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? Another patient/friend Another Doctor

Radio ad Magazine ad School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____

Street

Apartment #

City

State

Zip Code

