New Patient Form

Paul R. Feldman, DMD, FAGD, PA
1500 Pleasant Valley Way, Suite 202
West Orange, NJ 07052
973.669.0500
PFeldman@toothtalk.net
www.toothtalk.net

PATIENT INFORMATION

Patient's Name:				
Address:			Today's Date:	Date of Last Visit:	Date of Med. History:
City, State, Zip:			Email:	
Home Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:
Cell Phone:		Whom may we thank for referring you to our office?		

Marital Status (Circle One)	Single	Married	Widowed	Divorced	Separated	Domestic Partner

Primary Dental Guarantor:	Home Phone:	Work Phone:
Secondary Dental Guarantor:	Home Phone:	Work Phone:
Physician Name:	Physician Phone:	
Pharmacy:	Pharmacy Phone:	

Sex:	Height:	Weight:

RESPONSIBLE PARTY INFORMATION

Person Responsible for the Account:	Relationship to Patient:
Address:	Social Security Number:
Employer:	Employer Phone Number:

PRIMARY INSURANCE INFORMATION

Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	Group or Plan:
Insured's Name:	Insured's Birthdate:
Relationship:	Insured's Social Security Number:
Insured's Employer:	Employer's Address:

SECONDARY INSURANCE INFORMATION

Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	Group or Plan:
Insured's Name:	Insured's Birthdate:
Relationship:	Insured's Social Security Number:
Insured's Employer:	Employer's Address:

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PATIENT MEDICAL HISTORY

Patient's Name: | Date of Birth:

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH?	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE LAST YEAR?	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S)?	☐	☐
INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICINE(S) ARE YOU TAKING? _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
9. DO YOU BRUISE EASILY?	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
13. DO YOU USE TOBACCO?	☐	☐
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
15. ARE YOU WEARING CONTACT LENSES?	☐	☐
16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

Y	N	ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:
☐	☐	Local/Dental Anesthetics like Novocaine
☐	☐	Penicillin or Other Antibiotics
☐	☐	Sulfa Drugs
☐	☐	Barbiturates, Sedatives or Sleeping Pills
☐	☐	Aspirin
☐	☐	Iodine
☐	☐	Any Metals (E.G., Nickel, Mercury, Etc.)
☐	☐	Latex/Rubber
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Tetracycline

Other (Please List) _____

Y	N	DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:
☐	☐	Rheumatic Heart Disease or Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Heart Defect or Heart Murmur
☐	☐	Heart Trouble, Heart Attack, or Angina
☐	☐	Chest Pain
☐	☐	Shortness of Breath
☐	☐	Pacemaker
☐	☐	Heart Surgery
☐	☐	High/Low Blood Pressure
☐	☐	Congenital Heart Problem
☐	☐	Radiation Therapy
☐	☐	Colitis
☐	☐	Swelling of Feet, Ankles, Hands
☐	☐	Hepatitis, Jaundice or Liver Disease
☐	☐	Stroke
☐	☐	Sinus Trouble
☐	☐	Lung or Breathing Problems
☐	☐	Asthma or Hay Fever
☐	☐	Hives or Skin Rash
☐	☐	Fainting or Dizzy Spells
☐	☐	Diabetes
☐	☐	AIDS or HIV Infection
☐	☐	Thyroid Problems
☐	☐	Allergies
☐	☐	Arthritis or Rheumatism
☐	☐	Joint Replacement or Implant
☐	☐	Stomach Ulcer
☐	☐	Kidney Trouble
☐	☐	Tuberculosis
☐	☐	Persistent Cough
☐	☐	Cough that Produces Blood
☐	☐	Chemotherapy (Cancer, Leukemia)
☐	☐	Sexually Transmitted Disease
☐	☐	Psychiatric Problems
☐	☐	Frequent Headaches
☐	☐	Difficulty Breathing
☐	☐	Blood Transfusion
☐	☐	Hemophilia
☐	☐	Epilepsy or Seizures
☐	☐	Anemia
☐	☐	Glaucoma
☐	☐	Nervousness
☐	☐	Tonsillitis
☐	☐	Tumors
☐	☐	Mental Health Care
☐	☐	Back Problems
☐	☐	Chemical Dependency
☐	☐	Mitral Valve Prolapse
☐	☐	Cortisone Treatment
☐	☐	Cold Sores/Fever Blisters
☐	☐	Hypoglycemia
☐	☐	Eating Disorders
☐	☐	Abnormal Bleeding
☐	☐	Alcohol/Drug Abuse
☐	☐	Artificial Bones
☐	☐	Veneral Disease
☐	☐	Yellow Jaundice
☐	☐	Sickle Cell Disease
☐	☐	Shingles
☐	☐	Pneumocystitis
☐	☐	Fever Blisters
☐	☐	Cosmetic Surgery
☐	☐	Artificial Heart Valve
☐	☐	Emphysema

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PATIENT DENTAL HISTORY

Patient's Name:	Date of Birth:	
Reason for This Visit:		
When Was Your Last Dental Visit:	What Was Done Then:	
How Often Did You Visit the Dentist Before Then:		
Previous Dentist (Name and Location):		
Have You Had a Complete Series of Dental Films (X-rays):	When:	Where:
How Often Do You Brush Your Teeth:	How Often Do You Floss Your Teeth:	
Is Your Drinking Water Fluoridated:		

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐	EVER WORN A BITE PLATE OR OTHER APPLIANCE?	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
CLICKING	☐	☐	DO YOU WEAR DENTURES OR PARTIALS?	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐	IF YES, DATE OF PLACEMENT: _____		
DIFFICULTY IN OPENING OR CLOSING	☐	☐	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	☐	☐
DIFFICULTY IN CHEWING	☐	☐			
DO YOU HAVE FREQUENT HEADACHES?	☐	☐			
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR — DATE

DOCTOR'S COMMENTS _____

_____

_____ SIGNATURE _____ DATE _____

_____

PATIENT NUMBER