

PARSIPPANY DENTAL CARE

PATIENT MEDICAL INFORMATION

Date Medical Update Signature Date Medical Update Signature

Date Driver's License # Marital Status M D S W
NAME(last) (first) (middle)
ADDRESS Apt#
City State Zip Phone #
Social Security # Cell Phone
Sex = M F Height Weight Date of Birth
Employer Bus.Address
Business Phone # E-Mail
Spouse's name Bus. Phone
Who may we thank for referring you to our office
Reason for today's visit

PLEASE PRESENT YOUR DENTAL INSURANCE CARD'S TO THE FRONT DESK TO COPY

DO YOU HAVE PRIMARY DENTAL INSURANCE YES NO
Subscriber name SS# DOB

DO YOU HAVE SECONDARY DENTAL INSURANCE YES NO
Subscriber Name SS# DOB

MEDICAL HEALTH

Name, complete address, and phone# for your physician

Last complete physical? Please list all prescription and non-prescription drugs you are using:

Do you take Vitamin E? YES NO Do you take Aspirin Daily? YES NO
Are you in good health YES NO
Please list all herbal supplements/remedies you are taking

Have there been any changes in your health within the past year YES NO If yes explain:

DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Table with 6 columns: Condition, Yes, No, Condition, Yes, No. Rows include Heart Disease, Asthma, Artificial Heart Valve, Hip/Joint replacement, Stroke, Other Respiratory Problems, Abnormal Blood Pressure, Heart Murmur/Mitro Valve Prolapsed(MVP), Bleeding abnormally/extractions/surgery, Rheumatic fever, Blood Diseases, Congenital Heart Defect, Anemia, Implant - Hip, Pacemaker, Etc. (specify), Sinus Trouble, Jaundice, Emphysema, Ulcers, Cough (Chronic), Arthritis, Tuberculosis, Diabetes, Hay Fever, Epilepsy, Hepatitis A B non-AB Date, Glaucoma, Is pre-med. required for dental visits, Thyroid problems, Blood Transfusion Date, Immune Deficiency, Are you subject to prolong bleeding, Are you subject to fainting spells?

WOMEN: ARE YOU PREGNANT Yes No DUE DATE:

Do you know your current Blood Pressure?

Are you allergic to: PENICILLIN CODEINE LOCAL ANESTHETICS LATEX OTHER

Any other Medical Problems not listed that you think we should know about

Do you use any tobacco products? Yes No how much daily?

How much alcohol do you consume daily/weekly What kind?

SIGNATURE Patient/Guardian (circle one)

## DENTAL HEALTH

Does food tend to become caught between your teeth.....	YES	NO
Do you feel you have bad breath.....	YES	NO
Do you have periodic dental check-ups .....	YES	NO
Do your gums feel tender?.....	YES	NO
Do you clench or grind your teeth while asleep or awake?.....	YES	NO
Do you have popping or clicking in your ears when you open or close your mouth?	YES	NO
Do you snore or gasp for air while sleeping?.....	YES	NO
Is there old dentistry you want replaced?.....	YES	NO
Do you have missing teeth? .....	YES	NO
Were you told why your missing teeth should be replaced.....	YES	NO
Have you had previous orthodontic treatment?.....	YES	NO
Do you have spaces you don't like?.....	YES	NO
Do you use dental floss daily?.....	YES	NO
Are any of your teeth: Chipped Protruding Sensitive Stained Worn Dark		
If you could safely and easily whiten your teeth, would you be interested?	YES	NO
Do you have any other concerns about your teeth?	YES	NO

If yes, what \_\_\_\_\_

What phrase best describes how you feel about losing your teeth:	It doesn't bother me
	I thought everyone did eventually
	I'll do my best to prevent it
	I'd do anything to save my teeth
What best describes how you feel about your smile?	Satisfied
	If it could be improved easily/inexpensively, I might consider
	I'd do anything to improve my smile
I general, how do you view dental treatment?	I'm fairly relaxed about it
	It makes me a little uneasy
	It makes me tense
	It makes me very anxious
	I get so anxious that sometimes I break out in a sweat

It would be helpful if you would indicate below what things you are looking for most in choosing your dentist \_\_\_\_\_

## FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible personal quality care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services are due at the time they are rendered, unless other arrangements have been discussed prior to the start of treatment.

Returned checks and balances older than 30 days are subject to additional collection fees and interest charges of 1 1/2% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment, and answer any questions relating to your insurance.

You must realize, however, that:

1- Your insurance is a contract between you, your employer and the insurance company.

We are not a party to that contract. Insurance pre-estimate and or insurance quotes are not a guarantee of payment.

2- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. Filing your dental forms is a courtesy that we extend to our patients; all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

SIGNATURE \_\_\_\_\_

Patient or Responsible party if other than patient

SHARED: HEALTHI