Print Form

SMILE CENTER

Address: 3086 Sate Route 27, Suite 5 Kendall Park, NJ **Phone:** (732) 422-1900 **Website:** www.ChavvaDDS.com

PATIENT INFORMATION

First Name:_____ MI _____ Last Name:_____ Todays Date: _____

Sex Male: ◯ Female: ◯ Date Of Birth: _____ Age: ____ SS#: _____ Email:_____

Address:_____ City: _____ State:____ Zip: _____

Home Phone: _____ Bus Phone: _____ Cell Phone: _____

Employer: _____ Medical Doctor:_____

Nearest relative not living with you: _____ Phone:_____

Method of Payment: ◯ Cash ◯ Check ◯ Credit Card Referred By: _____

PERSONAL INFORMATION

Marital Status: ◯ Married ◯ Divorce ◯ Legally Separated ◯ Widow ◯ Single

Employment: ◯ NA ◯ Full Time ◯ Part Time ◯ Retired

Student: ◯ NA ◯ Full Time ◯ Part Time School Name/Location: _____

RESPONSIBLE PARTY (if self, skip to the next section)

◯ Spouse ◯ Father ◯ Mother ◯ Other Home Phone: _____

Name: _____ SS#:_____ Date Of Birth: _____ Age: _____

Address:_____ City: _____ State:_____ Zip: _____

Employer: _____ Phone: _____

SECONDARY RESPONSIBLE PARTY (if different from above)

◯ Spouse ◯ Father ◯ Mother ◯ Other Home Phone: _____

Name: _____ SS#:_____ Date Of Birth: _____ Age: _____

Address:_____ City: _____ State:_____ Zip: _____

Employer: _____ Phone: _____

PRIMARY DENTAL INSURANCE COMPANY

Employer: _____

Address: _____

Phone: _____ Plan: _____

Insurance Company: _____

Group Name: _____

Group #: _____

Identification #: _____

Primary Insured: _____

Relationship to Primary Insured: _____

SECONDARY DENTAL INSURANCE COMPANY

Employer: _____

Address: _____

Phone: _____ Plan: _____

Insurance Company: _____

Group Name: _____

Group #: _____

Identification #: _____

Primary Insured: _____

Relationship to Primary Insured: _____

DENTAL INFORMATION

Reason for today's ◯ Emergency ◯ Exam ◯ Schedule Procedure ◯ Consultation

Are you in ◯ Yes ◯ No If yes, how long have you been in pain? _____

Please indicate if you have any of the following problems by checking off the

- ☐ Discomfort, Clicking or Jaw Popping
- ☐ Red, Bleeding or Swollen Gums
- ☐ Sensitive Tooth or Gum
- ☐ Blisters/Sores in or Around the Mouth
- ☐ Lost or Broken Filling(s)
- ☐ Teeth Grinding
- ☐ Ringing Ears
- ☐ Broken/Chipped Tooth
- ☐ Stained Teeth
- ☐ Locking Jaw
- ☐ Bad Breath
- ☐ Other (Please explain below)

Other: _____

Have you ever required pre-medication? ◯ Yes ◯ No ◯ Not Sure

Previous dentist: _____ Phone: _____

How many times per day do you brush? _____ How many times per week do you floss? _____

What type of toothbrush bristles do you use? ◯ Soft ◯ Medium ◯ Hard

MEDICAL HISTORY

Are you taking any following ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxer

☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other (list)

Other medications:_____

Do you have or have had any of the following diseases, medical conditions or procedure? Please check proper box.

Y	N		Y	N		Y	N	
☐	☐	Heart Attack/Stroke	☐	☐	Thyroid Problems	☐	☐	Cancer/Tumors
☐	☐	Heart Surgery/Pacemaker	☐	☐	Kidney Problems	☐	☐	Shingles
☐	☐	Heart Murmur	☐	☐	Liver Problems	☐	☐	Hepatitis
☐	☐	Rheumatic Fever	☐	☐	Respiratory Problems	☐	☐	HIV/AIDS/ARC
☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems	☐	☐	Arthritis/Rheumatism
☐	☐	Artificial Valves	☐	☐	Stomach Problems/Ulcers	☐	☐	Artificial Bones/Joints
☐	☐	Heart Disease	☐	☐	Psychiatric Problems	☐	☐	Emphysema
☐	☐	Congenital Heart Disease	☐	☐	Venereal Disease	☐	☐	Fainting/Seizures/Epilepsy
☐	☐	Chest Pains	☐	☐	Alcohol/Drug Abuse	☐	☐	Severe/Frequent Headache
☐	☐	Scarlet Fever	☐	☐	Tuberculosis TB	☐	☐	Frequent Neck Pain
☐	☐	Nervousness	☐	☐	Jaw Problems TMJ/TMD	☐	☐	Back Problems
☐	☐	Chemotherapy	☐	☐	Difficulty Breathing	☐	☐	Cosmatic Surgery
☐	☐	Asthma	☐	☐	Diabetes/Hypoglycemia	☐	☐	X-Ray or Cobalt Treatment
☐	☐	Leukemia	☐	☐	High/Low Blood Pressure	☐	☐	Glaucoma
☐	☐	Anemia	☐	☐	Bleeding Problems			

Are you currently or have you taken in the past (either orally or through IV) any of the following drugs:

Y	N		Y	N	
☐	☐	Actonel (Risedronate) for Osteoporosis	☐	☐	Aredia (Pamidronate) for Cancer, Pagets
☐	☐	Bonefos (Clondronate) for Cancer	☐	☐	Boniva (Ibandronate) Osteoporosis
☐	☐	Didronel (Etidronate) Pagets	☐	☐	Fosamax (Alendronate) Osteoporosis, Pagets
☐	☐	Ostac (Clondronate) Cancer	☐	☐	Skelid (Tiludronate) Pagets's
☐	☐	Zometa (Zoledronic Acid) Osteoporosis, Cancer			

MEDICAL HISTORY (continued)

List any of the medical condition(s) you have or have had: _____

_____

_____

Are you allergic to the following? ☐ Latex ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Penicillin/Amoxicillin ☐ Note Sure ☐ Other (list)

Other Allergies:_____

Do you smoke? ◯ Yes ◯ No How many per day? _____ How long have you smoked? _____

Other tobacco products? ◯ Yes ◯ No What type of tobacco? _____ How often? _____ How long? _____

Please rate your general health 1-10: _____ Do you wear contact lenses? ◯ Yes ◯ No

Have you ever taken the drug Phen-fen or Redux? ◯ Yes ◯ No

For Women Only:

Have you taking Birth Control pills? ◯ Yes ◯ No

How many children have you birthed? _____

Are you currently pregnant? ◯ Yes ◯ No If yes, how many months are you? _____

Are you nursing? ◯ Yes ◯ No

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. If the account is not paid in full of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process
insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date:_____

◯ Adult Patient ◯ Parent or Guardian ◯ Spouse

UPDATE

(Office Use Only)

Initials: _____ Date: _____

Comments: _____

Initials: _____ Date: _____

Comments: _____

Initials: _____ Date: _____

Comments: _____