WELCOME TO OUR PRACTICE

Rahway DENTAL GROUP
(732) 388-0314 www.rahwaydental.com

PATIENT INFORMATION

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell (_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ Medical Doctor _____ Referred By _____
FIRST NAME LAST NAME FIRST NAME LAST NAME FIRST NAME LAST NAME

Driver's Lic. # _____ Nearest relative not living with you _____ Tel. (_____) _____
FIRST NAME LAST NAME

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who may we thank for referring you to our office ❑ our website ❑ dental insurance website ❑ internet search

❑ patient of practice _____ ❑ Other _____

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____
(If self, skip to next section)

Name _____ S.S.# _____ Birth Date _____ Age ____ Tel.(_____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information *(if different from above)*

Name _____ Relation _____ S.S.# _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School info _____ _____
SCHOOL NAME ADDRESS

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____ _____ _____
CITY STATE ZIP

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

1 PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ _____ ____ _____
CITY STATE ZIP

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ _____ _____ Tel. (_____) _____
CITY STATE ZIP

Group # _____ Group Name _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

Tel. (_____) _____ S.S. # _____

I.D. # _____

2 SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ _____ ____ _____
CITY STATE ZIP

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ _____ _____ Tel. (_____) _____
CITY STATE ZIP

Group # _____ Group Name _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

Tel. (_____) _____ S.S. # _____

I.D. # _____

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PATIENT'S 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) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO BITING OR PRESSURE	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	☐	☐
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
HAVE YOU EVER HAD ORTHODONTIC (BRACES) TREATMENT	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

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

_____

_____

HEALTH HISTORY

To our patients: Although dentists 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 care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

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Reason for today's office visit _____

		Yes	No
99.	Are you in good health? Height _____ Weight _____	❑	❑
100.	Have there been any changes in your general health in the past year?	❑	❑
101.	Are you under the care of a physician? Date of last visit _____	❑	❑
	If so, for what are you being treated? _____		
102.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
103.	Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? *If so, described where* _____	❑	❑
104.	Do you have a prosthetic joint/implant? *If so, describe where* _____	❑	❑
105.	Have you had a heart valve replacement or vascular graft?	❑	❑

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .		Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain / angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Snoring / sleep apnea?			
120	Difficulty breathing / other lung trouble?			
121	Tuberculosis?			
122	Emphysema?			
123	Do you use tobacco? (smoking, chew, bidis) If so, how interested are you in stopping? Circle one: very somewhat not interested			
124	Blood transfusion?			
125	Blood disorder such as anemia?			
126	Bruise easily?			
127	Bleeding tendency / abnormal bleed?			
128	Hepatitis, jaundice, or liver disease?			
129	Infectious mononucleosis?			
130	Gallbladder trouble?			
131	Fainting spells?			
132	Convulsions / epilepsy?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .		Yes	No	NOTES
133	Stroke?			
134	Thyroid trouble?			
135	Diabetes?			
136	Low blood sugar?			
137	Kidney trouble?			
138	Are you on dialysis?			
139	Swollen ankles, arthritis or joint disease?			
140	Stomach ulcers?			
141	Contagious diseases?			
142	Sexually transmitted diseases?			
143	Are you immunosuppressed? (possibly from transplant surgery, etc.)			
144	Problems with the immune system? (possibly from medication / surgery, etc.)			
145	Delay in healing?			
146	A tumor or growth?			
147	Radiation therapy / chemotherapy?			
148	Chronic fatigue / night sweats?			
149	Are you on a diet?			
150	A history of drug abuse?			
151	Do you drink alcoholic beverages? If yes, how much do you typically drink in a week?			
152	Contact lenses?			
153	Eye disease / glaucoma?			
154	Mental health problems?			
155	A removable dental appliance?			
156	Pain and clicking of jaws when eating?			
157	Malignant hyperthermia?			
158	IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours?			
159	Who is driving you home?			

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MEDICATION - Are you now taking or have you taken. . .

		Yes	No	NOTES
201	Any kind of medication. drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			
206	Have you ever taken tranquilizers, sleeping pills, anti depressants, and /or narcotics on a regular basis? If so, please list:			
207	Please list any medications you are currently taking:			

ALLERGIES - Are you allergic to, or had a reaction to. . .

		Yes	No	NOTES
208	Local anesthetic (numbing Med.)?			
209	Penicillin			
210	Other antibiotics?			
211	Sulfa Drugs?			
212	Sodium pentothal, Vallium, or other tranquilizers?			
213	Aspirin?			
214	Codeine or other narcotics?			
215	Other medications?			
216	Latex?			
217	Soy?			
218	Eggs / Yolks?			
219	Sulfites?			
220	Please list any allergies other than drug allergies:			

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No *(If so, describe)*

Do you wish to speak to the doctor privately about anything?
❑ Yes ❑ No

Is there a **FAMILY HISTORY** of:
301 Cancer: ❑ Yes ❑ No
302 Diabetes: ❑ Yes ❑ No
303 Heart Disease: ❑ Yes ❑ No
304 Anesthetic Problems: ❑ Yes ❑ No

IN CASE OF EMERGENCY CONTACT:
Name _____
Home Tel.(_____) _____
Bus. Tel. (_____) _____

IS THIS VISIT RELATED TO AN ACCIDENT?: Automobile: ❑ Yes ❑ No
Work Related: ❑ Yes ❑ No
Date of Injury _____ Other: ❑ Yes ❑ No

Insurance company handling this claim _____
Claim number _____
Name of Attorney / Adjuster _____
Telephone number (_____) _____

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW.
WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

401 Expected delivery date _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills? ❑ Yes ❑ No

Women Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

I certify that I have read and I understand the questions above. I acknowledge that my questions, it any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X _____ Reviewed by: X _____ Date: X _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any dental procedure you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X _____ Date: X _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X _____ Date: X _____

AUTHORIZATION

I authorize my dentist and his / her designated staff, to perform an oral examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X _____ X _____ Witness: X _____

Date Signature of patient: *(Parent or Guardian if minor)* Doctor: X _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X _____ Date: X _____