Morristown
COSMETIC DENTISTRY

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name: Last_____ First_____ Middle Initial _____

Street Address _____

_____

City_____ State_____ Zipcode _____

Primary Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Birthdate ____/___ _/_____ Social Security # _____--_____--_____ Sex: Male / Female Marital: S / M / D / W

Employer _____

Occupation_____ No. Years Employed _____

In case of an emergency, whom should we contact?_____ Phone Number _____

Who may we thank for referring you to our office? _____

If Patient is a minor, give Parent's or Guardian's Name _____

DENTAL INSURANCE INFORMATION

Insured Subscriber Name _____ Patient Relationship to Subscriber _____

Subscriber SS# or Member ID# _____ Subscriber D.O.B. _____

Insurance Co. Name and Address_____

_____

Subscriber's Employer _____ Group # _____

If you have another dental insurance, complete the section below for secondary coverage

Insured Subscriber Name _____ Patient Relationship to Subscriber _____

Subscriber SS# or Member ID# _____ Subscriber D.O.B. _____

Insurance Co. Name and Address_____

_____

Subscriber's Employer _____ Group # _____

Dental History

How long has it been since your last dental cleaning? _____ Months Do you use dental floss? _____

Do your gums bleed, or feel tender or irritated? _____ (**please circle**) Are your teeth sensitive to **hot, cold, sweets, pressure**?

Are you happy with the appearance of your teeth? _____ Have you ever worn braces? _____

Are you aware of grinding or clenching your teeth?_____ Do you have headaches, earaches, or neck pains? _____

Medical History

Do you have any current health problems? (If yes, please explain)

_____

_____

Physician Name _____ Phone _____

Please list all medications that you are taking and dosage

_____

_____

Do you smoke? _____ Have you ever smoked?

Women Only: Are you pregnant? _____ Nursing? _____ Birth Control Pills? _____

PLACE A CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAVE OR SUSPECT:

Arthritis		High Low Blood Pressure		Tuberculosis		Fainting Tendency		Blood Transfusions		Fever Blisters	
Rheumatic Fever		Stroke		Diabetes		Epilepsy		Cortisone Drugs		**List Other Below**	
Heart Disease/ Attack		Short of Breath		Kidney/ Bladder Trouble		Thyroid Disease		Steroids			
Heart Murmer		Asthma or Hay Fever		Anemia		Glaucoma		Blood Thinners			
Mitral Valve Prolapse		Sinus Trouble		Lung Disease		Radiation/ Chemotherapy		Bisphosphonates			
Artificial Heart Valve		Hepatitis or Jaundice		Venereal Disease		Mental Disorders		Tranquilizers			
Heart Pacemaker		Liver Disease		Blood Disease		HIV or AIDS		Drug Addiction			
Heart Surgery		Cancer or Tumor		Prolonged Bleeding		Prosthetic Joint Replacement		Alcoholism			

ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves

Other _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

Signature _____ **Date** _____