PRACTICE LIMITED TO PEDIATRIC DENTISTRY
NJ SPECIALTY PERMIT #s 3001 & 6340
AND
ORTHODONTICS
NJ SPECIALTY PERMIT # 3211

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14 Westfield Avenue, East
Roselle Park, NJ 07204

Date:_____

PLEASE PRINT

Personal History

Patient's name:(Dr., Mr., Mrs., Ms. or Miss): _____Date of Birth_____

Address:_____Phone#_____
Number Street City/State Zip

Home Phone: _____CellPhone_____

EMAIL ADDRESS: _____ (to be used only for appointment related information)

Patient SS#:_____Patient's Age:_____Patient's weight:_____

Employer:_____Employer Phone#:_____

Can we call you at work?_____

Employer Address:_____
Number Street City/State Zip

Spouse's Name:_____Date of Birth_____

Address(if different):_____Phone#_____
Number Street City/State Zip

Employer:_____Employer Phone#:_____

Employer Address:_____
Number Street City/State Zip

DENTAL INSURANCE INFORMATION

If you have dental insurance coverage, please complete below:

Your Insurance_____
Insurance Company Name Group#

Address_____
Insurance Company Address Phone Number

Spouse's Insurance_____
(If you are covered) Insurance Company Name Group #

Address_____
Insurance Company Address Phone Number

Authorization to Release Information:

I hereby authorize the above named dentist(s) to provide any insurance company(s), claims administrative(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits. I am aware that I am financially responsible for any charges not covered by my insurance carrier.

_____
Authorized Signature Date

PLEASE COMPLETE OTHER SIDE →

Dental History

Name of your Dentist:_____City:_____Phone#:_____

When was your last visit to the dentist?_____

What is the reason for your visit today?_____

Medical History

Name of Physician:_____City:_____Phone#_____

Name of Pharmacy:_____ Phone# _____

Do you have any allergies?_____

Are you taking medication?_____For what reason?_____

Have you ever had a reaction to any medication, such as penicillin, aspirin?_____

What type of reaction?_____

Have you ever been a patient in a hospital or emergency room?_____If yes, for what reason?_____

_____

Are there any medical conditions we need to be aware of?_____

Please check if you've had any of the following. ***At what age?***

( ) Heart Disease	( ) Kidney Disease	( ) T.B.	( ) High Blood Pressure	( ) Cancer
( ) Asthma	( ) Liver Disease	( ) Rheumatic Fever	( ) Endocrine Disorders	( ) Chemotherapy
( ) Anemia	( ) Epilepsy	( ) Hemophilia	( ) Hepatitis	( ) Radiation Treatment
( ) Heart Murmur	( ) Convulsions	( ) Sickle Cell	( ) HIV/AIDS	
( ) Frequent Colds	( ) Diabetes	( ) Bleeding Problems	( ) STD	

( ) None

( ) Other (Please Explain):_____

Has anyone in the immediate (mother, father, siblings and grandparents) family ever had any of the following?

( ) Diabetes ( ) Heart Disease ( ) Cancer ( ) T.B. ( ) Bleeding Problems ( ) None

Signature: _____

Comments: