

# New Patient Form



Paul R. Feldman, DMD, FAGD, PA  
 1500 Pleasant Valley Way, Suite 202  
 West Orange, NJ 07052  
 973.669.0500  
 PFeldman@toothtalk.net  
 www.toothtalk.net

## PATIENT INFORMATION

Patient's Name:					
Address:			Today's Date:	Date of Last Visit:	Date of Med. History:
City, State, Zip:			Email:		
Home Phone:	Work Phone:	Birth Date:	Social Security No.:	Marital Status:	
Cell Phone:		Whom may we thank for referring you to our office?			
Marital Status (Circle One)      Single                  Married                  Widowed                  Divorced                  Separated                  Domestic Partner					
Primary Dental Guarantor:			Home Phone:	Work Phone:	
Secondary Dental Guarantor:			Home Phone:	Work Phone:	
Physician Name:			Physician Phone:		
Pharmacy:			Pharmacy Phone:		

Sex:	Height:	Weight:
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## RESPONSIBLE PARTY INFORMATION

Person Responsible for the Account:	Relationship to Patient:
Address:	Social Security Number:
Employer:	Employer Phone Number:

## PRIMARY INSURANCE INFORMATION

Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	Group or Plan:
Insured's Name:	Insured's Birthdate:
Relationship:	Insured's Social Security Number:
Insured's Employer:	Employer's Address:

## SECONDARY INSURANCE INFORMATION

Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	Group or Plan:
Insured's Name:	Insured's Birthdate:
Relationship:	Insured's Social Security Number:
Insured's Employer:	Employer's Address:

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## PATIENT MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL 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 DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE LAST YEAR?	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU HAD A RECENT WEIGHT LOSS?	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			13. DO YOU USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	15. ARE YOU WEARING CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S)?	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	<input type="checkbox"/>	<input type="checkbox"/>
INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICINE(S) ARE YOU TAKING? _____	<input type="checkbox"/>	<input type="checkbox"/>	17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING?	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b>		
9. DO YOU BRUISE EASILY?	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
			ARE YOU NURSING?	<input type="checkbox"/>	<input type="checkbox"/>
			ARE YOU TAKING BIRTH CONTROL PILLS?	<input type="checkbox"/>	<input type="checkbox"/>

Y	N	ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:
<input type="checkbox"/>	<input type="checkbox"/>	Local/Dental Anesthetics like Novocaine
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or Other Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs
<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, Sedatives or Sleeping Pills
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (E.G., Nickel, Mercury, Etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Latex/Rubber
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
Other (Please List) _____		
Y	N	DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart Disease or Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart Defect or Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble, Heart Attack, or Angina
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Problem
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet, Ankles, Hands
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice or Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Lung or Breathing Problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Hives or Skin Rash
<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough
<input type="checkbox"/>	<input type="checkbox"/>	Cough that Produces Blood
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer, Leukemia)
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Care
<input type="checkbox"/>	<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones
<input type="checkbox"/>	<input type="checkbox"/>	Veneral Disease
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystitis
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema

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## PATIENT 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):		When:	Where:
How Often Do You Brush Your Teeth:		How Often Do You Floss Your Teeth:	
Is Your Drinking Water Fluoridated:			

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE?	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS?	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE)	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT: _____		
DIFFICULTY IN OPENING OR CLOSING	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>			

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

\_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X \_\_\_\_\_ DATE \_\_\_\_\_  
 SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
 PATIENT NUMBER