DENTAL HEALTH CENTER
OF MONMOUTH BEACH

PATIENT INFORMATION

Date _____

Patient's Name_____

Address_____Town_____State_____Zip_____

Home Phone_____Cell_____ Work phone_____

Birthdate_____ SS#_____Email address_____

Marital Status:_____

Whom may we "Thank" for referring you to our practice:_____

RESPONSIBLE PARTY INFORMATION

Name_____

Address_____

Employer_____Occupation_____No. of years employed_____

SS#_____ Birthdate_____ Relationship to Patient_____

EMERGENCY INFORMATION

Person to contact/Relationship_____

Complete Address_____

Phone Cell_____Work_____Home_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's SSN _____ Date of Birth _____

Insurance Company_____Group#_____ID#_____

Insurance Company Address_____

Do you have dual (2nd) coverage? Yes____ No____ If yes:

Insured's name_____ Insured's Soc Sec #_____

Insurance Co._____ Group #_____ ID#_____

Insurance Company Address_____

Insured's Employer_____

Signature (Parent's signature if pt. is a minor) _____

HEALTH HISTORY

The following information is very important and will aid us in caring for your dental needs.

1. Are you having pain or discomfort at this time?.....Yes / No
2. Have you ever fainted in a dental office?.....Yes / No
3. Have you had a serious accident or head injury?.....Yes / No
4. Have you been a patient in a hospital in the past two years?.....Yes / No
   If yes, what is the reason_____
5. Do you smoke or chew tobacco?.....Yes / No
6. Have you been under the care of a medical Doctor during the past two years?.....Yes / No
7. Name of physician_____Phone_____
8. Have you taken any prescription medication or drugs during the past two years……Yes / No
9. Are you taking any medication, drugs, or pills?.....Yes / No
   If yes, please list:_____
10. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? Latex? If so, please list_____
11. Do you take or have you ever taken Bisphosphonate (Fosamax)?.....Yes / No

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. CIRCLE "YES" OR "NO" FOR EACH;

Heart Failure	**Yes / No**	**Anticoagulant Medicine**	**Yes / No**	**Cold Sores/Fever Blisters**	**Yes / No**
Heart Disease or Attack	**Yes / No**	**Glaucoma**	**Yes / No**	**Epilepsy or Seizures**	**Yes / No**
Angina Pectoris	**Yes / No**	**Pain in Jaw Joints**	**Yes / No**	**Fainting/Dizzy Spells**	**Yes / No**
High Blood Pressure	**Yes / No**	**A.I.D.S.**	**Yes / No**	**Nervousness**	**Yes / No**
Low Blood Pressure	**Yes / No**	**HIV Positive**	**Yes / No**	**Depression**	**Yes / No**
Mitral Valve Prolapse	**Yes / No**	**Hepatitis A**	**Yes / No**	**Memory Loss**	**Yes / No**
Heart Murmur	**Yes / No**	**Hepatitis B**	**Yes / No**	**Psychiatric Treatment**	**Yes / No**
Rheumatic Fever	**Yes / No**	**Hepatitis C**	**Yes / No**	**Sickle Cell Disease**	**Yes / No**
Congenital Heart Defect	**Yes / No**	**Liver Disease**	**Yes / No**	**Bruise Easily**	**Yes / No**
Scarlet Fever	**Yes / No**	**Jaundice**	**Yes / No**	**Allergies to Jewelry**	**Yes / No**
Artificial Heart Valve	**Yes / No**	**Blood Transfusion**	**Yes / No**	**Emphysema**	**Yes / No**
Heart Pacemaker	**Yes / No**	**Hemophilia**	**Yes / No**	**Cough**	**Yes / No**
Heart Surgery	**Yes / No**	**Chemotherapy**	**Yes / No**	**Tuberculosis**	**Yes / No**
Artificial Joint	**Yes / No**	**Radiation Therapy**	**Yes / No**	**Asthma**	**Yes / No**
Anemia	**Yes / No**	**Arthritis**	**Yes / No**	**Hay Fever**	**Yes / No**
Stroke/TIA	**Yes / No**	**Rheumatism**	**Yes / No**	**Sinus Trouble**	**Yes / No**
Kidney Trouble	**Yes / No**	**Cortisone Medicine**	**Yes / No**	**Allergies/Hives**	**Yes / No**
Ulcers	**Yes / No**	**Alcohol/Drug Addiction**	**Yes / No**	**Diabetes**	**Yes / No**
Cosmetic Surgery	**Yes / No**	**STD**	**Yes / No**	**Thyroid Disease**	**Yes / No**

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?_____ Yes / No

Do you snore?_____ Yes / No

Have you been diagnosed with sleep apnea?_____ Yes / No

Do you use more than 2 pillows to sleep?_____ Yes / No

Have you lost/gained more than 10 pounds in the past year?_____ Yes / No

Do you ever wake up from sleep short of breath?_____ Yes / No

Are you on a special diet?_____ Yes / No

Do you bleed excessively when cut?_____ Yes / No

Has your medical doctor ever said you have cancer or a tumor?_____ Yes / No

Do you have or have had an eating disorder?_____ Yes / No

Do you have any disease, condition or problem not listed? Please describe._____

Is there any other information concerning your health that we should know about? _____

_____

Women Only: Are you pregnant? If yes, what month._____

Are you nursing?_____

Are you taking birth control pills?_____ Reviewed by_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my belief. I hereby authorize The Dental Health Center of Holmdel and their staff to perform for me and/or my dependents such dental treatment medication or therapy as they deem appropriate and in connection therewith take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.

Patient_____ Date_____

Parent or Responsible Party_____ Relationship to Patient_____