MONTCLAIR DENTAL

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CONFIDENTIAL PATIENT INFORMATION

DATE: _____

PATIENT INFORMATION

PATIENT NAME_____
(First- Middle initial-Last)
HOME ADDRESS_____
CITY, STATE, ZIP_____
HOME PHONE_____ CELL_____
WORK #_____
EMAIL ADDRESS_____
BIRTHDATE_____ SS#_____
EMPLOYER NAME_____
PRESENT POSITION_____

RESPONSIBLE PARTY INFORMATION

NAME_____
(If different than patient)
BILLING ADDRESS _____
CITY, STATE, ZIP_____
HOME PHONE_____ CELL_____
WORK #_____
EMAIL ADDRESS_____
BIRTHDATE_____ SS#_____
RELATIONSHIP TO PATIENT_____
EMPLOYER NAME_____

BEST WAY TO CONTACT YOU TO CONFIRM APPOIINTMENTS (circle) Home Work Cell Email Other
MARITAL STATUS:(circle one) Minor Single Married Divorced Widowed Separated Life Partner Sig. Other Spouse/Partner's Name_____
WHOM MAY WE THANK FOR REFERRING YOU?_____
PERSON TO CONTACT IN CASE OF EMERGENCY:_____PHONE #_____
IF FULL TIME COLLEGE STUDENT: NAME OF SCHOOL _____
CITY & STATE _____

IF PATIENT IS AN ELIGIBLE DEPENDENT UNDER AGE 26:

PATIENT LIVES WITH: [Circle which one(s) apply.] SELF MOTHER FATHER STEPMOTHER STEPFATHER GUARDIAN OTHER
PARENTS ARE: [Circle which one(s) apply.] Married Divorced Separated Remarried Widowed Other_____
FATHER'S NAME_____
STEPFATHER'S NAME_____
GUARDIAN'S NAME_____
MOTHER'S NAME_____
STEPMOTHER'S NAME_____
OTHER NAME_____

PRIMARY DENTAL INSURANCE

NAME OF INSURED_____
INSURED'S HOME ADDRESS_____
CITY, STATE, ZIP_____
HOME PHONE_____ CELL_____
WORK PHONE_____BIRTHDATE_____
SS#_____ INS. ID #_____
RELATIONSHIP TO PATIENT_____
NAME OF EMPLOYER_____
EMPLOYER'S MAIN PHONE #_____
INSURANCE COMPANY_____

SECONDARY DENTAL INSURANCE

NAME OF INSURED_____
INSURED'S HOME ADDRESS_____
CITY, STATE, ZIP_____
HOME PHONE_____ CELL_____
WORK PHONE_____BIRTHDATE_____
SS#_____INS. ID #_____
RELATIONSHIP TO PATIENT_____
NAME OF EMPLOYER_____
EMPLOYER'S MAIN PHONE #_____
INSURANCE COMPANY_____

OVER PLEASE

HEALTH HISTORY

Name of Physician_____ Date of Last Medical Exam _____

Have you had any serious illness or operation? YES NO If YES, explain_____

Do you have any allergies (medications, metals, etc?) YES NO explain_____

Have there been any notable changes in your health in the last year? YES NO explain_____

Are you taking any medications? YES NO Please list_____

_____

(If you are taking several, please provide a list from a physician or ask us to contact them to acquire a formal list)

WOMEN ONLY: Are you presently pregnant or have reason to believe you may be pregnant? YES NO
Are you currently taking birth control pills? YES NO

Circle any of the following conditions that you have or have been treated for:

Heart Trouble	Hepatitis or Jaundice	Cancer or Tumor	Heart Murmur
Arthritis	Radiation Therapy	Blood Pressure	Chemotherapy
Artificial Hips/Joints/Implants	AIDS or HIV	Rheumatic Fever	Stomach Ulcer
Frequent/Easy Bruises	Kidney Disease	Smoking	Sinus Troubles
Tuberculosis	Stroke	Cardiac Pacemaker	Epilepsy/Seizures
Bisphosphonate/Osteoporosis	Psychiatric Treatment	Diabetes	Drug Addiction/Use

If there is any other disease, condition, or problem we should know about, please explain:
_____

DENTAL HISTORY

What is the reason you are seeking dental treatment at this time?_____

What concerns do you have about your mouth?_____

What, if anything, in the past has prevented you from seeking dental treatment?_____

Are you happy with your smile and front teeth?_____

Circle any of the following conditions that you have or have been treated for:

Biting Sensitivity	Cold Sensitivity	Food Catching Between Teeth
Gum Disease	Shifting/Crowded Teeth	Tooth Loss
Bleeding Gums	Bad Bite	Bad Breath
Headaches or Facial Pain	Grinding/Clenching Teeth	Cosmetic Dental Work
Frequent Broken Teeth	Orthodontics/Braces	Bone Loss
Denture Problems	TMJ Problems	Frequent Cavities
Snoring/Sleep Apnea	Nightguard	Dental Implants

Any other dental conditions or problems that we should know about? _____

*Please bring your insurance card to your first visit so that we can make a copy of it to submit all claims to your insurance company and maximize insurance benefits. I understand the above information is necessary to provide me with the best dental care possible and I attest that I have answered all questions accurately and to my best knowledge. I authorize the provider to release information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group all insurance benefits. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf of my dependents.

SIGNATURE_____ DATE_____