ELEGANT SMILES OF MATAWAN

Patient Information

First Name_____ Last Name_____

Address_____ City/State/Zip_____

Social Security#_____ Home #_____

Birthday_____ Cell #_____

Email_____ Age_____

Company_____ Occupation_____

Address_____ Work #_____Ext_____

City/State/Zip_____ Marital Status_____

How did you hear about us?_____

Emergency Contact_____ Phone #_____

Responsible Party (If other than pt)_____ Address_____

Home #_____ Cell #_____

Insurance Information

Name of Insured_____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Birth date_____ Insured SS_____ Employer_____

Insurance Co._____ Phone #_____ Group #_____

Address_____ City/State/Zip_____

Dental History

Reason for today's visit_____

Last Exam_____ Last Full Mouth X-rays_____

Last Dentist_____ Last Cleaning_____

Pain in Mouth? No Yes_____

What don't you like about your smile? _____

_____

Check All That Apply:

☐Bad Breath	☐Crooked Teeth	☐ Jaw Clicking	☐Sleep Apnea
☐Bleeding Gums	☐Discoloration	☐Jaw Pain	☐Snoring
☐Broken Teeth	☐Grinding	☐Loose Teeth	☐Swelling
☐Clenching	☐Headaches	☐Mouth Pain	☐Teeth Sensitivity
☐Cold Pain	☐Hot Pain	☐Pain Chewing	☐Worn Teeth

Confidential Medical History

Physician Name_____ Phone #_____

Any surgical procedures within past 12 months? N Y_____

Any hospitalizations within the past 12 months? N Y_____

Have you taken *Phen-Fen* or *Redux*? N Y_____

Do you use tobacco? N Y_____

Have you ever had *Rheumatic Fever, Scarlet Fever*, or *Rheumatic Heart Disease*? N Y

Have you ever taken *Actonel/Boniva/Fosamex* or any other *Bisphosphonates*? If Yes, List:_____

Women:

☐ Pregnant ☐ Nursing ☐ Oral Contraceptives

Taking Medications? List: List Any Allergies:

_____ _____

_____ _____

_____ _____

Do you have, or have you had, any of the following? CHECK ALL THAT APPLY

__AIDS/ HIV Positive	__Chest Pains	__Frequent Headaches	__Hypoglycemia	__Rheumatism
__Alzheimers Disease	__Cold Sores/Fever Blisters	__Genital Herpes	__Irregular Heartbeat	__Shingles
__Anaphylaxis	__Congenital Heart Disorder	__Glaucoma	__Kidney Problems	__Sickle Cell Disease
__Anemia	__Convulsions	__Hay Fever	__Leukemia	__Sinus Trouble
__Angina	__Cortisone Meds	__Heart Attack/Failure	__Liver Disease	__Spina Bifida
__Arthritis/Gout	__Diabetes	__Heart Murmur	__Low Blood Pressure	__Stomach/Intestine
__Artificial Heart Valve	__Drug Addiction	__Heart Pacemaker	__Lung Disease	__Stroke
__Artificial Joint	__Easily Winded	__Heart Disease/Trouble	__Mitral Valve Prolapse	__Swelling of Limbs
__Asthma	__Emphysema	__Hemophilia	__Osteoporosis	__Thyroid Disease
__Blood Disease	__Epilepsy/Seizures	__Hepatitis A	__Pain in Jaw Joints	__Tonsillitis
__Blood Transfusion	__Excessive Bleeding	__Hepatitis B/C	__Parathyroid Disease	__Tuburculosis
__Breathing Problem	__Excessive Thirst	__Herpes	__Psychiatric Care	__Tumors/Growths
__Bruise Easily	__Fainting Spells/Dizziness	__High Blood Pressure	__Radiation Treatments	__Ulcers
__Cancer	__Frequent Coughs	__High Cholesterol	__Recent Weight Loss	__Venereal Disease
__Chemotherapy	__Frequent Diarrhea	__Hives or Rash	__Renal Dialysis	__Yellow Jaundice

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

*SIGNATURE OF PATIENT, PARENT, OR GUARDIAN*_____*DATE*_____