NEWARK DENTAL ASSOCIATES
PATIENT INFORMATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) HOME PHONE _____

Name _____ Cell Phone _____
Last First Middle Preferred Name

Social Security No. _____

○ Male ○ Female Date of Birth _____ Age _____ ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Street Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Work Phone (_____) _____

Spouse/Parent Name _____ Date of Birth _____

Employed by _____ Social Security _____

Business Address _____ Work Phone (_____) _____

Person responsible for payment _____ Relationship to patient _____

Address _____ Phone No. (_____) _____

Primary Dental Insurance Co. _____ Subscriber's Name _____

_____ ○ Active

Insurance Co. Address _____ Subscriber's I.D. No. _____ ○ Retired

Secondary Dental Insurance Co. _____ Subscriber's Name _____

_____ ○ Active

Insurance Co. Address _____ Subscriber's I.D. No. _____ ○ Retired

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In case of Emergency Contact _____ Phone No. (_____) _____

Address _____ Relationship to Patient _____

Referred by _____ Date of Last Dental Visit _____

Full Time Student? ○ Yes ○ No If Yes, Name of School _____ Last update with Insurance on _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ (Name of Insurance Companies) and assign directly to Newark Dental Associates all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: _____ Signature: _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ (Name of patient) do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date: _____ Signature: _____

CONTINUED ON BACK

MEDICAL HISTORY

Patient's Name _____ Date of Birth ____/____/____ Height _____ Weight _____

Physician's Name _____ Physician's Phone No. _____ Date of Last Physical _____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Are you taking any medication now? ☐ Yes ☐ No PLEASE LIST _____

_____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

Abnormal Bleeding	Y ○ N ○	Fainting Spell	Y ○ N ○	Pacemaker	Y ○ N ○
Alcohol Dependency	Y ○ N ○	Fever Blisters	Y ○ N ○	Positive for HIV or AIDS	Y ○ N ○
Anemia	Y ○ N ○	Frequent Headaches	Y ○ N ○	Psychiatric Problems	Y ○ N ○
Angina Pectoris	Y ○ N ○	Glaucoma	Y ○ N ○	Radiation Therapy	Y ○ N ○
Arthritis	Y ○ N ○	Heart Attack	Y ○ N ○	Rheumatic Fever	Y ○ N ○
Artificial Heart Valves	Y ○ N ○	Heart Surgery	Y ○ N ○	Seizures	Y ○ N ○
Asthma	Y ○ N ○	Hemophilia	Y ○ N ○	Sickle Cell Disease	Y ○ N ○
Blood Transfusion	Y ○ N ○	Hepatitis Type_____	Y ○ N ○	Sinus Problems	Y ○ N ○
Cancer-Chemotherapy	Y ○ N ○	High Blood Pressure	Y ○ N ○	Stroke	Y ○ N ○
Congenital Heart Defect	Y ○ N ○	Heart murmur	Y ○ N ○	Thyroid Disorder	Y ○ N ○
Depression	Y ○ N ○	Joint Replacement(When_____)	Y ○ N ○	Tuberculosis	Y ○ N ○
Diabetes	Y ○ N ○	Kidney Problems	Y ○ N ○	Ulcers	Y ○ N ○
Drug Dependency	Y ○ N ○	Liver Disorders	Y ○ N ○	Unexplained Weight Loss	Y ○ N ○
Emphysema	Y ○ N ○	Low Blood Pressure	Y ○ N ○	Venereal Disease	Y ○ N ○
Epilepsy	Y ○ N ○	Mitral Valve Prolapse	Y ○ N ○	Yellow Jaundice	Y ○ N ○

Have you ever taken **Fen-Fen, Pondimin, or Redux**? When? _____ How long? _____ Are you taking herbs or vitamin supplements? _____

Have you been hospitalized or had a serious illness in the last five years? ○ Yes ○ No If yes please describe: _____

Are you allergic to(or have reacted adversely to) ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Injected Local Anesthetics ☐ Latex ☐ Others, please describe: _____

_____ Other medical problems: _____

Are you under the care of a physician? ○ Yes ○ No Why? _____ Do you use tobacco products ○ Yes ○ No If yes how much a day? ____

WOMEN: Are you using **birth control pills?** ○ Yes ○ No Do you suspect that you are **pregnant?** ○ Yes ○ No How long _____ Are you nursing? ○ Yes ○ No

*** If you cannot keep your appointment, please give us 24 hours notice to avoid additional charges. A $30 charge will be applied to your account if you fail to keep your appointment or if you cancel with less than 24 hours notice.**

*** Some services may not be covered by insurance. We will help you to submit your insurance form one time for each claim.**

*** Payments at the time of the visit are appreciated. Finance charges will be added to the balance after 60 days.**

I hereby authorize and direct payment to Newark Dental Associates for dental benefits, if any, otherwise payable to me under the terms of any applicable insurance. I authorize the release of any dental information necessary to process claims. I certify that the above information is accurate and complete to the best of my knowledge.

PATIENT'S SIGNATURE _____ Date _____

For Office Use Only

1. Has patient had any recent illness or accident? 2. Is there any change on the medication that patient takes? Is there any other information that should be known about patient's health? Has patient had any change in the Address, Phone Number, or Dental Insurance?

DATE:	CHANGES	DATE:	CHANGES

NOTES: