(908) 355-0300
324 Morris Ave.
Elizabeth, NJ 07208
www.elitesmile.com

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

Chart# ___________

Today's Date: ___/___/___

Name ____ **Social Security #:** _______-_____-_______
Last First Middle Initial

Home Phone:(____) _____-______ **Mobile Phone:**(____) _____-______ **Other Phone:**(____) _____-______

Email address________________________________ **Second Email Address**_______________________________________

Home Address: ____________________________________ **apt#** _____ ____
City State Zip Code

Birth Date:____/____/_____ **o Male** **o Female** **o Single** **o Married** **o Divorced** **o Widowed**

Occupation:________________________________ **Your Employer:** _________________________________

Address: ____________________________________ ____
Street City State Zip Code

Work Phone:(___) ____-_____

Referred By:____

In the event of an emergency, is there someone who lives near you that we could contact?

Name ____ **Relation:**_________________________

Home Phone:(___) ____-_____ **Other Phone:**(___) ____-_____

Dental Insurance Information

Patient's Name:____ **Relation To Insured:** ______________________

Date of Birth: ______/_______/________ **SS#:** __________-_________-__________

Subscriber's Name: ____

Date of Birth: _____/______/_______ **SS#:** _________-_________-___________ **Group Number**____________________

Insurance Name:_________________________________ **Telephone Number:**(____) _____-______

Address: ____________________________________ ____
Street City State Zip Code

***Insurance coverage is not a guarantee of payment by insurance companies. Any balance not cover by insurance company is strictly the patient's responsibility

Medical History

Do you have a personal physician o Y o N His / Her name______________________ His / Her phone:__________________________

The approximate date of your last visit:______________ Your current Physical health is o Good θ Fair θ Poor

Are you currently under the care of any physician? θ Y θ N If yes, please explain: ______________________________________

Do you smoke or use tobacco in any other form? θ Y o N Are currently taking any drugs prescribed by physician or dentist? o Y o N

If yes, please list: ____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) **o Y o N** If yes, when: ____

For women: Are you pregnant o Y o N Week # ________

Do you need to be premedicated before a dental treatment o Y o N

Have you had any serious medical problems in the last 5 years o Y o N

If yes, please explain: ______________________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

o Y o N Anemia
o Y o N High / Low Blood Pressure
o Y o N Chronic Hepatitis
o Y o N Diabetes
o Y o N Drug / Alcohol Abuse
o Y o N Epilepsy / Seizures / Fainting Spells
o Y o N Fever Blisters
o Y o N Heart Attack / Stroke
o Y o N Heart Murmur / Rheumatic Fever
o Y o N Heart Surgery / Pacemaker
o Y o N Hemophilia / Abnormal Bleeding
o Y o N Cancer / Chemotherapy
o Y o N HIV+ / AIDS
o Y o N Kidney Problems
o Y o N Psychiatric Problems
o Y o N Severe Headaches
o Y o N Shingles
o Y o N Sickle Cell Disease / Traits
o Y o N Sinus Problems
o Y o N Tuberculosis (TB)

Office Use Only / Doctor's comments: ____

Have You Experienced Any Other Medical Condition Not Listed Above: o Y o N

If yes, please List: ____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS

o Y o N Aspirin o Y o N Codeine o Y o N Dental Anesthetics o Y o N Erythromycin o Y o N Penicillin
o Y o N Tetracycline
Are you allergic to any other drugs? o Y o N If yes, please List: ____

Dental History

Why have you come to the dentist today? ____

Are you currently in pain? o Y o N Do you require antibiotics before a dental treatment? o Y o N

Are you under any unusual stress at home or work? o Y o N Do you experience stress or anxiety when you visit a dental office? o Y o N

The approximate date of your last dental visit: _______________________

Have you ever experienced TMJ Problems? (TMJ is pain or discomfort in your jaw joints) o Y o N

Your current dental health is o Good o Fair o Poor

o Y o N Do you grind your teeth
o Y o N Do your gums ever bleed?
o Y o N Do you like your smile?
o Y o N Would you like to prevent dentures?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature______________________________ Date________________