ENGLEWOOD DENTAL, P.A.
370 Grand Avenue, Englewood, NJ 07631

Today's Date:__________

WELCOME
REGISTRATION

PERSONAL DATA

Name:________________________________
First M.I. Last
I prefer to be called:____________ Sex: M/F
Birthdate: / / Age: SS#: / /
Home Address: _________________________
____
Home #: _________________________
Cell Number___________________________
Work #:__________________ Ext:________
Email Address:_________________________
Occupation:____________________________
Responsible Party:______________________
( ) Single ( ) Married ( ) Divorced ( ) Widowed
Spouse Information
His/Her Name:_________________________
Occupation:____________________________
Birthdate: / / Age: SS#: / /

Dental Insurance
Ins. Co. Name:__________________________
Address: _____________________________
____
Ins. Co. Tel. #: _________________________
Group Name: __________________________
Group Number: _________________________

Employer: ____________________________
Employer's Address: ____________________
____
Spouse's Employer: ____________________
Employer's Address: ____________________
____

Whom may we thank for referring you? (Please be specific)
1) Friend/Relative:________________ 2) Englewood Magazine______ 3) Radio____4) Star Ledger_______ 5) Yellow Book______6) Mailing_____7) Doctor:________________8) MDTV ________ 9) Verizon Yellow Book______10) Bergen Record_______ 11) Bergen News _____12) 201 Magazine _______ 10) Other________ 11) Internet_________

DENTAL HISTORY

Why have you come to the dentist today?____
Are you currently in pain?____
Have you ever had a serious/difficult problem associated with any previous dental work?__________
Do you or have you ever had pain/discomfort in your jaw joint (TMJ)? Yes_________ No__________
Your current dental health is? Good__ Fair_______ Poor_______
Do you like your smile? Yes_________ No___
Do your gums ever bleed? Yes_ No___
How many times a week do you floss? _______
How many times a day do you brush? _______ Type of bristles? Hard_____ Med___ Soft ____
Last Dental Visit date: _________________________
Last Dental X-Rays: _________________________
Are you interested in replacing any missing teeth? Yes____________ No___
Do you presently wear any removable bridges or dentures? Yes_____ No___
Are you interested in doing away with your removable dentures? Yes___ No___
Are you interested in the benefits of nutritional supplementation? Yes____ No___

Doctor's Dental Note:______________________________

MEDICAL HISTORY

Your current physical health is ( ) Good ( ) Fair ( ) Poor
Are you currently under the care of a physician? ( ) Yes ( ) No
Please explain:______________________________
Are you taking any prescription/over-the-counter drugs? ( ) Yes ( ) No
Please list each one: ______________________________

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack/Stroke	Y	N	Congenital Heart Defect/ Artificial Valve
Y	N	Heart Murmur	Y	N	High/Low Blood Pressure
Y	N	Heart Surgery/Pacemaker	Y	N	Anemia
Y	N	Mitral Valve Prolapse	Y	N	Blood Transfusion
Y	N	Psychiatric Problems	Y	N	Hepatitis A B C
Y	N	Cancer/Chemotherapy/Radiation	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Shingles	Y	N	Venereal Disease
Y	N	Rheumatic Fever	Y	N	HIV+/AIDS
Y	N	Kidney Problems	Y	N	Liver problems
Y	N	Tuberculosis (TB)	Y	N	Asthma/Difficulty Breathing
Y	N	Sinus Problems	Y	N	Arthritis
Y	N	Epilepsy/Seizures/Fainting Spells	Y	N	Diabetes
Y	N	Osteoporosis	Y	N	Drug/Alcohol Abuse
Y	N	Severe/Frequent Headaches	Y	N	Ulcers/Colitis
Y	N	Hospitalized for any reason	Y	N	Smoking

Please list any medical condition(s) that you have ever had: ______________________________

____

Are you presently taking /have you ever taken medications for osteoporosis? (Bisphosphonates) Y N
Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Dental Anesthetics
Y	N	Aspirin	Y	N	Codeine
Y	N	Other ______________________________			

For Women: Are you taking birth control pills? ( ) Yes ( ) No
Are you pregnant? ( ) Yes ( ) No Week #:__________________
Are you nursing? ( ) Yes ( ) No

In the event of emergency, is there someone that we should contact?
Their Name:______________________ Relation: ______________________
Work #:______________________ Home #: ______________________

I understand that the information that I have given today is correct to the best of my knowledge. I authorize my dentist to make photos, slides, x-rays, or any other visual aids of my treatment to be used for the advancement of dentistry in any manner my dentist deems appropriate.

PATIENT SIGNATURE:______________________________ DATE:____________________

Doctor's Comments: ______________________________