Carey Family Dentistry

40 State Route 34, Suite A, Old Bridge, NJ 08857 · (732) 727-7110

Patient Information

PATIENT INFORMATION (PLEASE PRINT)

Date | Last Name | First Name | Middle Initial

Address

City | State | ZIP | Birthdate

Sex: ☐ M ☐ F | Age | Email

Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Patient Employer / School | Occupation

PHONE NUMBERS

Home Phone | Cell Phone | Best time / place to reach you

IN CASE OF EMERGENCY, CONTACT (SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)

Name | Relationship | Phone

REFERRAL

Whom may we thank for referring you?

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Dental Insurance

RESPONSIBLE PARTY

Who is responsible for this account?

Relationship to Patient

PRIMARY INSURANCE

Insurance Company

Group #

Subscriber's Name

Birthdate

Relationship

Is patient covered by additional insurance? ☐ Yes ☐ No

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Company

Group #

Subscriber's Name

Birthdate

Relationship

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Carey Family Dentistry all insurance 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 authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient / Parent / Guardian

Date

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Dental History

VISIT DETAILS

Reason for today's visit

Former Dentist

City / State

Date of last dental visit

Date of last dental X-rays

PLEASE INDICATE YES OR NO

Bad breath	☐ Y ☐ N	Food collection between teeth	☐ Y ☐ N	Orthodontic treatment	☐ Y ☐ N
Bleeding gums	☐ Y ☐ N	Foreign objects	☐ Y ☐ N	Pain around ear	☐ Y ☐ N
Blisters on lips or mouth	☐ Y ☐ N	Grinding teeth	☐ Y ☐ N	Periodontal treatment	☐ Y ☐ N
Burning sensation on tongue	☐ Y ☐ N	Gums swollen or tender	☐ Y ☐ N	Sensitivity to cold	☐ Y ☐ N
Chew on one side of mouth	☐ Y ☐ N	Jaw pain or tiredness	☐ Y ☐ N	Sensitivity to heat	☐ Y ☐ N
Cigarette, pipe, or cigar smoking	☐ Y ☐ N	Lip or cheek biting	☐ Y ☐ N	Sensitivity to sweets	☐ Y ☐ N
Clicking or popping jaw	☐ Y ☐ N	Loose teeth or broken fillings	☐ Y ☐ N	Sensitivity when biting	☐ Y ☐ N
Dry mouth	☐ Y ☐ N	Mouth breathing	☐ Y ☐ N	Sores or growths in your mouth	☐ Y ☐ N
Fingernail biting	☐ Y ☐ N	Mouth pain, brushing	☐ Y ☐ N		

How often do you floss?

How often do you brush?

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Health History

PHYSICIAN INFORMATION

Physician's Name

Date of last visit

Have you ever used a bisphosphonate medication (e.g. Fosamax, Actonel, Boniva)? ☐ Yes ☐ No

Have you ever taken “fen-phen” type drugs (phentermine, fenfluramine, dexfenfluramine)? ☐ Yes ☐ No

PLEASE INDICATE YES OR NO FOR EACH

AIDS/HIV	☐ Y	☐ N	Fainting or dizziness	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Anemia	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N
Arthritis, Rheumatism	☐ Y	☐ N	Headaches	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
Artificial Heart Valves	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Sinus Trouble	☐ Y	☐ N
Artificial Joints	☐ Y	☐ N	Heart Problems	☐ Y	☐ N	Skin Rash	☐ Y	☐ N
Asthma	☐ Y	☐ N	Hepatitis (any type)	☐ Y	☐ N	Special Diet	☐ Y	☐ N
Back Problems	☐ Y	☐ N	Herpes	☐ Y	☐ N	Stroke	☐ Y	☐ N
Bleeding abnormally (extractions/surgery)	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Swollen Feet or Ankles	☐ Y	☐ N
Blood Disease	☐ Y	☐ N	Jaundice	☐ Y	☐ N	Swollen Neck Glands	☐ Y	☐ N
Cancer	☐ Y	☐ N	Jaw Pain	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N
Chemical Dependency	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Circulatory Problems	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N	Tumor or growth (head/neck)	☐ Y	☐ N
Congenital Heart Lesions	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N	Ulcer	☐ Y	☐ N
Cortisone Treatments	☐ Y	☐ N	Nervous Problems	☐ Y	☐ N	Venereal Disease	☐ Y	☐ N
Cough, persistent or bloody	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Weight Loss, unexplained	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Psychiatric Care	☐ Y	☐ N	Wear contact lenses	☐ Y	☐ N
Emphysema	☐ Y	☐ N	Radiation Treatment	☐ Y	☐ N			
Epilepsy	☐ Y	☐ N	Respiratory Disease	☐ Y	☐ N			

WOMEN

Pregnant? ☐ Y ☐ N Due date Nursing? ☐ Y ☐ N Birth control pills? ☐ Y

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Medications, Allergies & Consent

MEDICATIONS

List any medications you are currently taking, and the correlating diagnosis

Pharmacy Name

Pharmacy Phone

ALLERGIES

- [ ] Aspirin
- [ ] Iodine
- [ ] Penicillin
- [ ] Barbiturates (sleeping pills)
- [ ] Latex
- [ ] Sulfa
- [ ] Codeine
- [ ] Local Anesthetic

Other allergies (please list)

ACKNOWLEDGMENT & SIGNATURE

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I acknowledge receipt of the practice's Notice of Privacy Practices (HIPAA) and financial policy, including a 24-hour cancellation notice requirement. I understand that providing false information can be dangerous to my health and agree to notify the office of any changes to the information provided here.

- [ ] I acknowledge and agree to the above

Patient / Parent / Guardian Signature

Date