ANNA PATRAS, D.M.D., P.A.

13 Main Street • Suite 7 Sparta • NJ 07871 • (973) 729 5900

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Patient's Name ______________________________ Date __________ Age ______
First Middle Last

Birth Date ____/____/____ Home Phone # (   ) ______ – ______ Cell Phone # (   ) ______ – ______

Email ______________________________

Street Address ______________________________ City __________ State ______ Zip ______

Other Family Members seen by us: ______________________________

Who may we thank for referring you to our office? ______________________________

RESPONSIBLE PARTY INFORMATION

Name ______________________________ Relationship to patient ______________

Address ______________________________ City __________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________ SS# ______________

Employer ______________________________ How long at current employment? ______

Work Phone ______________ Marital Status ______ Does responsible party have legal custody? ______

RESPONSIBLE PARTY'S SPOUSE / OTHER RESPONSIBLE PARTY INFORMATION

Name ______________________________ Relationship to patient ______________

Address (if different from above) ______________________________ City __________ State ______ Zip ______

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________________________ SS# ______________

DENTAL INSURANCE INFORMATION - PRIMARY CARRIER -

Insured's Name ______________________________

Insurance Co. ______________________________

Insurance Co. Address ______________________________

Insurance Phone # ______________________________

Policy # ______________________________

Date of Birth ______________________________

DENTAL INSURANCE INFORMATION - SECONDARY CARRIER -

Insured's Name ______________________________

Insurance Co. ______________________________

Insurance Co. Address ______________________________

Insurance Phone # ______________________________

Policy # ______________________________

Date of Birth ______________________________

This office will gladly submit for the insurance benefits, however you are responsible for any co-payment, deductible and balance that the insurance does not cover.

PLEASE FILL OUT BOTH SIDES

Patient's Name ____
First Middle Last

PLEASE FILL OUT ALL THAT APPLY TO THE PATIENT

General Dentist ______________________ When was your last visit with your dentist? ______________

Current Dental Health ☐ Good ☐ Fair ☐ Poor

Any injuries to face, mouth, chin, teeth? ☐ Yes ☐ No

Tonsils and Adenoids removed? ☐ Yes ☐ No

Extra or missing permanent teeth? ☐ Yes ☐ No

Tenderness in jaw or joint? ☐ Yes ☐ No

Has patient ever been evaluated for orthodontic treatment before? ☐ Yes ☐ No

DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS

______ Clenching / Grinding Teeth ______ Lip Sucking / Biting ______ Mouth Breather ______ Nail Biting

______ Nursing Bottle Habits ______ Speech Problems ______ Thumb / Finger Sucking ______ Tongue Thrust

MAIN CONCERN FOR YOUR VISIT ____

____

MEDICAL HISTORY

Current physical health? ☐ Good ☐ Fair ☐ Poor

PLEASE MARK ALL OF THE FOLLOWING MEDICAL PROBLEMS THAT APPLY TO THE PATIENT

______ Abnormal Bleeding	______ Anemia / Radiation Treatment	______ Artificial Bones / Joints / Valves
______ Blood Transfusion	______ Cancer / Chemotherapy	______ Congenital Heart Defect
______ Diabetes	______ Difficulty Breathing	______ Drug / Alcohol Abuse
______ Emphysema / Glaucoma	______ Epilepsy / Seizures / Fainting	______ Fever Blisters / Herpes
______ Heart Attack / Stroke	______ Heart Murmur	______ Heart Surgery / Pacemaker
______ Hemophilia	______ Hepatitis	______ High / Low Blood Pressure
______ HIV + / AIDS	______ Hospitalized for any Reason	______ Kidney Problems
______ Mitral Valve Prolapse	______ Psychiatric Problems	______ Rheumatic / Scarlet Fever
______ Severe / Frequent headaches	______ Shingles	______ Sinus Problems
______ Tuberculosis (TB)	______ Ulcers / Colitis	______ Venereal Disease

Please discuss any medical conditions: ____

____

____

Please list any allergies: ______________________ Please list all drugs patient is currently taking: ______________________

______________________ ______________________

Has puberty begun? ☐ Yes ☐ No (For Women Only) Has menstruation begun? ☐ Yes ☐ No Approximate age ________

EMERGENCY INFORMATION

In case of Emergency, who may we call? Name ______________________ Phone # ( ) ____________

Relationship to Patient ______________ Physician ______________________ Phone # ( ) ____________

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 strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ____ **Date** ____________