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 _____

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

Email _____

Street Address _____ City _____ State _____ Zip _____

Sibling's Names and Ages _____

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.

Patient's Name _____ _____

PLEASE FILL OUT ALL INFORMATION COMPLETELY

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	☐ Yes ☐ No	Mouth Breather	☐ Yes ☐ No
Nursing Bottle Habits	☐ Yes ☐ No	Thumb / Finger Sucker	☐ Yes ☐ No
Lip Sucking / Biting	☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No
Speech Problems	☐ Yes ☐ No	Tongue Thrust	☐ Yes ☐ No

MAIN CONCERN FOR YOUR VISIT _____

_____

MEDICAL HISTORY

Current physical health? ☐ Good ☐ Fair ☐ Poor

DOES PATIENT HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS:

Abnormal Bleeding	☐ Yes ☐ No	Epilepsy / Seizures / Fainting	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anemia / Radiation	☐ Yes ☐ No	Fever Blisters / Herpes	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Artificial Bones / Joints / Valves	☐ Yes ☐ No	Heart Attack / Stroke	☐ Yes ☐ No	Rheumatic / Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Severe / Frequent headaches	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Surgery / Pacemaker	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Cancer / Chemotherapy	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	High / Low Blood Pressure	☐ Yes ☐ No	Ulcers / Colitis	☐ Yes ☐ No
Difficulty Breathing	☐ Yes ☐ No	HIV + / AIDS	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Drug / Alcohol Abuse	☐ Yes ☐ No	Hospitalized for any Reason	☐ Yes ☐ No		
Emphysema / Glaucoma	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No		

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** _____

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