Dental Care HILLSBOROUGH

706 US Highway 206, Hillsborough, NJ 08844 • (908) 448-2227 • DentalCareHillsborough.com

Patient's Name:_____ How do you prefer to be addressed?_____ Sex (Circle One): Male Female
Birth Date:____ /_____ /_____ Age:_____ Marital Status (Circle One): Single Married Widowed Separated Divorced
SS#:_____ Mailing Address:_____ City:_____ State:_____ Zip:_____
E-mail: _____ Home Phone: (_____) _____ Cell: (_____) _____
Dental Insurance Carrier:_____ Policy Holder: _____ Policy Holder DOB: _____
Insurance ID Number: _____ Work Phone: (_____) _____
Occupation:_____ Employer: _____
If Student, Name of School/College: PT FT _____ City: _____ State: _____ Zip: _____
Who can we thank for referring you to our office? _____

If the person responsible for payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip.

Name of Responsible Party: _____ Relationship to Patient: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
E-mail: _____ Home Phone: (_____) _____ Cell: (_____) _____
Work Phone: (_____) _____ Occupation: _____ Employer: _____

Medical History

Date of last complete physical:_____ Medical Doctor's Name: _____ Doctor's Phone #:(_____) _____
Are you taking any medication, vitamins, or supplements? Bisphosphonates? Yes / No Please list: _____
Do you smoke? Yes _____ No _____ If yes, how much a day? _____
Are you pregnant? Yes _____ No _____ If yes, how many months? _____
Are you allergic to: (Select all that apply) Penicillin Codeine Local injected anesthetic Latex Other: _____
Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

_____

Have you been told that you need to take antibiotics prior to dental cleanings or other treatment? Yes___ No___
Medication & Reason: _____
Do you have or have you ever had any of the following? Check all that apply:

____ Heart attack
____ Heart murmur
____ Heart condition
____ MVP
____ Pacemaker
____ Stroke
____ Malignancies
____ Radiation treatments
____ Thyroid Disease
____ Epilepsy
____ Anemia
____ Prolonged bleeding
____ High or low blood pressure (circle one)
____ Diabetes
____ Hepatitis
____ Jaundice
____ Arthritis
____ Rheumatism
____ Joint replacements
____ Ulcers
____ Herpes
____ AIDS/HIV positive
____ Asthma
____ Hay fever
____ Sinus trouble
____ Persistent cough
____ Psychiatric care or Nervous problems
____ Narrow angle glaucoma
____ Excessive urination
____ Sensitivity to epinephrine
____ Implants
____ Headaches/Migraines
____ Pain/Soreness (circle one) ears, eyes, face
____ Stiff neck, jaw pain, or TMJ (circle one)
____ Clicking or popping in jaw
____ COVID-19; Date of positive test result: _____
____ Soreness in jaw
____ Is it hard for you to open wide?
____ Snoring
____ Dry mouth
____ Bad breath or sour taste
____ Sensitivity to hot and cold
____ Burning sensations in mouth
____ Bleeding gums
____ Food catching between teeth

What is most important to you about your teeth? _____
How would you rate the appearance of your smile? (Select one) Excellent ☐ Good ☐ Fair ☐ Poor ☐
If you could change anything about your smile, what would it be? _____
Does having dental treatment make you afraid or nervous? Y ☐ N ☐ If yes, what specific things bother you? _____

_____

Communication Preferences:

☐ Do not leave a detailed message ☐ Office may leave a detailed message which may contain medical/dental information at the following phone number(s): ☐ Cell ☐ Home

Is there anyone other than the patient we may speak to regarding any dental treatment information?

Name of Person:_____ Relationship to Patient: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Hillsborough to check and verify my credit and/or employment history. I further understand that Dental Care Hillsborough will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I give permission for phone calls and visits to be recorded for internal training purposes. If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient. We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

I agree that, should I test positive for COVID-19 within 14 days following my dental appointment, I will immediately contact my doctor.

Signature of Patient or Guardian: _____ Date:_____ /_____ /_____