Medical History Notes, Current Medications, Consults
(office use only)

Date	

Steven Denholtz, D.M.D.
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973-252-1600

WELCOME!
We are interested in the best dental health care for you. In order to do this, we must know some things about you. Please fill in this form carefully. Of course, all information will be held strictly confidential.

PATIENT INFORMATION

First Name:_____ Last Name:_____
Street:_____
City, State, Zip_____
Date of Birth: _____/_____/_____ Sex:_____ Marital Status_____
Phone Home_____ Email_____
Work_____ (Parent's for a child) Cell#_____

FINANCIAL RESPONSIBILITY

Person responsible for Payment:_____
Street:_____
City, State, Zip:_____
EMPLOYER:_____
Address:_____
Occupation:_____

DENTAL INSURANCE

☐ One ☐ Two policies are in effect.

Insurance Company:_____
Address:_____
Name of Employee:_____ Birthdate:_____
Employee's Social Security Number:_____
Employee's Local #:_____ Group #:_____
Employee's Group Name:_____
Patient's Relation to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other

I agree I am responsible for all costs of services rendered, regardless of insurance. I authorize the release of information to appropriate parties and assign insurance benefits to Steven Denholtz DMD. I authorize and consent to Dr. Denholtz and his staff performing such procedures that in Dr. Denholtz professional judgment are necessary. I agree that balances over 60 days are subject to 19.8%apr interest and I authorize charging my credit and/or debit card on any portion of such late balance and agree to pay attorneys' fee of 33.3% and collection cost on late balances. I have had the opportunity to read the HIPPA "notice of privacy" and agree to its terms.

Signature_____

OPTIONAL BUT HELPFUL...

How did you hear about our office?_____
Any comments you feel would help us serve you better?_____

MEDICAL HISTORY

Patient's Physician: _____

Dr.'s City/Phone: _____

How is your general health? _____

Do you or have you ever had?

	YES	NO		YES	NO
1) Rheumatic Fever	[ ]	[ ]	10) Bleeding problem	[ ]	[ ]
2) Heart murmur	[ ]	[ ]	11) Epilepsy	[ ]	[ ]
3) Hepatitis	[ ]	[ ]	12) Sexually transmitted disease	[ ]	[ ]
4) Diabetes	[ ]	[ ]	13) Artificial joint(s) or valve(s)	[ ]	[ ]
5) Heart condition	[ ]	[ ]	14) Pacemaker	[ ]	[ ]
6) Frequent Headaches	[ ]	[ ]	15) Psychiatric problem	[ ]	[ ]
7) Digestive problems	[ ]	[ ]	16) Infectious disease or H.I.V.	[ ]	[ ]
8) Asthma	[ ]	[ ]	17) Cancer or Leukemia	[ ]	[ ]
9) Radiation treatment	[ ]	[ ]	18) Ever Taken Medicine(s) for Osteoporosis	[ ]	[ ]

17) Any medical condition? _____

18) Blood pressure is (Low) (Normal) (High) (Don't know)

19) Allergic to? (Penicillin) (Codeine) (Novocaine) (Other): _____

20) Recent operations or hospitalizations? _____

21) What medications, vitamins or homeopathic substances, if *any* are you taking?

22) How much do you use:

Coffee/Tea _____ Cigarettes, pipe or cigars _____

Smokeless Tobacco _____ Alcoholic beverages _____

23) Are you pregnant? (No) (Yes) - > How many weeks? _____ Due date _____

24) Are you taking oral contraceptives "the pill"? _____

DENTAL HISTORY

25) Reason for this visit? _____

26) Last dental exam? _____

27) Do you avoid any part of your mouth due to sensitivity? _____

28) Do any teeth hurt? _____ (now) (cold) (hot) (sweets) (chewing) (change of position) (brushing)

Do you or have you ever had?

	YES	NO		YES	NO
29) Gum disease	[ ]	[ ]	32) Clicking or pain on opening	[ ]	[ ]
30) Bleeding or tender gums	[ ]	[ ]	33) Facial pain or earache	[ ]	[ ]
31) A sinus condition	[ ]	[ ]	34) Clenching or grinding teeth	[ ]	[ ]

35) A removable denture (bridge)? _____ How old? _____

36) Do you like your smile (how it looks)? _____

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Please hand this to the receptionist when you have finished both sides. Thank you.