Confident Smile Locations:
187 Livingston Avenue New Brunswick
or 1496 Morris Avenue Union

Today's Date:

WELCOME REGISTRATION

PERSONAL DATA

Name:

First Middle Last
Sex: M/F
Birthdate: / / Age: SS#: / /

Home Address: ____________________
____
____
Home number : ____________________ Cell number : ____________________
Work number: ____________________ Ext: ____________________
Email Address: ____________________
Occupation: ____________________
Responsible Party: ____________________

( ) Single ( ) Married ( ) Divorced ( ) Widowed

Spouse Information:
His/Her Name: ____________________
Occupation: ____________________
Birthdate: / / Age: SS#: / /

Dental Insurance
Ins. Co. Name: ____________________
Address: ____________________
Ins. Co. Tel ____________________ Group Name: ____________________
Group Number: ____________________

Employer: ____________________ Employer Address: ____________________
____

Spouse's Employer ____________________
Employer Address: ____________________

Whom may we thank for referring you? (Please be specific)

1) Friend/Relative: ________________________ 2) Mailing: ________________________
3) Doctor: ________________________ 4)Website: ________________________
5) Internet: ________________________ 6) Other: ________________________

Dental History:
Why have you come to the dentist today? ________________________
Are you currently in pain? ________________________
Have you ever had a serious/difficult problem associated with any previous dental work?
____
Do you or have you ever had pain/discomfort in your jaw joint (TMJ)? Yes No
Your current dental health is? Good Fair Poor
Do you like your smile? Yes No
Do your gums ever bleed? Yes No
How many times a week do you floss?
How many times a day do you brush?
Type of bristles? Hard Med Soft
Last Dental Visit date: ________________________
Last Dental X-Rays: Home Address: ________________________
Are you interested in replacing any missing teeth? Yes No
Do you presently wear any removable bridges or dentures? Yes No
Are you interested in doing away with your removable dentures? Yes No

Doctor's Dental Note: ________________________

MEDICAL HISTORY

Your current physical health is ( ) Good ( ) Fair ( ) Poor
Are you currently under the care of a physician? ( ) Yes ( ) No
Are you taking any prescription/over-the-counter drugs? ( ) Yes ( ) No
Please list each one: ________________________

Have you ever had any of the following diseases or medical problems?
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Cancer/Chemotherapy/Radiation
Y N Shingles
Y N Rheumatic Fever
Y N HIV+/AIDS
Y N Liver problems
Y N Asthma/Difficulty Breathing
Y N Congenital Heart Defect/Artificial Valve
Y N High/Low Blood Pressure
Y N Anemia
Y N Blood Transfusion
Y N Hepatitis A B C
Y N Hemophilia/Abnormal Bleeding
Y N Venereal Disease
Y N Arthritis
Y N Kidney Problems
Y N Tuberculosis (TB)
Y N Sinus Problems

Y N Epilepsy/Seizures/Fainting Spells
Y N Osteoporosis
Y N Severe/Frequent Headaches
Y N Hospitalized for any reason
Y N Diabetes
Y N Drug/Alcohol Abuse
Y N Ulcers/Colitis
Y N Smoking

Please list any medical condition(s) that you have ever had:: ____________________

Are you presently taking /have you ever taken medications for osteoporosis? (Bisphosphonates)
Y N
Are you allergic to any of the following drugs?
Y N Penicillin
Y N Aspirin
Y N Other ____________________
Y N Dental Anesthetics
Y N Codeine

For Women: Are you taking birth control pills? ( ) Yes ( ) No

Are you pregnant? ( ) Yes ( ) No Week #:
Are you nursing? ( ) Yes ( ) No

In the event of emergency, is there someone that we should contact?

Their Name: ____________________

Relation: ____________________

Work #: ____________________

Home #: ____________________

I understand that the information that I have given today is correct to the best of my knowledge. authorize my dentist to make photos, slides, x-rays, or any other visual aids of my treatment to be used for the advancement of dentistry in any manner my dentist deems appropriate.

Patient Signature: ____________________ Date: ____________________
Doctor's Comment: ____________________