BEAUTIFUL SMILES NJ
GENERAL DENTISTRY • ORTHODONTICS • DENTAL IMPLANTS

ADULT PATIENT INFORMATION

Name:____ Date: ________/________/________

How did you hear about us?

____

Reason for the visit today?

____

Birthdate: ________/________/________ Age:______ Sex: _____Male ____Female

Address:____
Street City Zip

Home Phone:_______________ Work Phone:_______________ Cell Phone:_______________

Employer:_______________________ City:________________ Occupation:________________

Email Address:_________________________________

Marital Status: Single___ Married___ Widowed___ Separated___ Divorced___

Spouse's Name:____

Employer:________________________ City:_______________ Occupation:________________

Work Phone:___________________

Dental Insurance Information

Insured's Name:__________________________ Insured Social Security #:__________________

Insurance Company:________________________________ Group No.___________________

Insurance Co. Address:______________________________ Phone No.___________________

Do you have orthodontic coverage? Yes___ No___

Do you have dual coverage? Yes___ No___

Insured's Name:__________________________ Insured Social Security #:__________________

Insurance Company:________________________________ Group No.____________________

Insurance Co. Address:______________________________ Phone No.___________________

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize Dr. Scott-Walenjus to release all information necessary to secure the payment of benefits. I assign directly to Dr. Scott-Walenjus all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature:____ Date: ________/________/________

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Dental History

General Dentist:____ Date of last visit:___________

Address:____

City State Zip

Yes No Have you had previous orthodontic treatment?

Details:____

Yes No Any injuries to teeth, mouth, or jaws?

Details:____

Yes No Do you require antibiotics before teeth cleanings or other dental appointments?

Details:____

Yes No Does your jaw ever click or get sore (TMJ/TMD)? If yes, when?

Details:____

Yes No Do you ever clench your teeth during?

Details:____

Yes No Do you grind your teeth?

Details:____

Yes No Do you ever have trouble opening your mouth as wide as you would like?

Details:____

Yes No Have you ever been informed of having any missing or extra permanent teeth?

Details:____

Yes No Have you ever lost or chipped any teeth?

Details:____

Yes No Is any part of your mouth sensitive to temperature? Where?

Details:____

Yes No Is any part of your mouth sensitive to pressure? Where?

Details:____

Yes No Have you ever seen a periodontist for periodontal treatment?

Details:____

Any other dental problems that we should know about?

Details:____

What specific concerns do you have regarding your teeth and how they look and function?

____

____

Medical History

Physician:____ Date of last visit:_____________

Address:____

City State Zip

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Check the medical conditions below that you ever had or been treated for:

- ☐ Abnormal bleeding/Hemophilia
- ☐ Allergies
- ☐ Anemia
- ☐ Artificial Bones/Joints/Valves
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer or Tumors
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures/Fainting
- ☐ Fever Blisters/Herpes
- ☐ Glaucoma
- ☐ Heart Attack/Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery/Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV+/AIDS
- ☐ Hospitalizations
- ☐ Kidney Problems
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Severe / Frequent Headaches
- ☐ Shingles
- ☐ Sickle Cell Disease / Trait
- ☐ Sinus Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers / Colitis

Please describe any serious medical conditions:

____

____

____

Please Circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medications?

Details:____

____

Yes No Have you ever taken Fosamax or any other bisphosphonate?

Details:____

Yes No Are you allergic to any medicine?

Details:____

Yes No Are you allergic to latex/metals/nickel/plastic?

Details:____

Yes No Do you smoke or chew tobacco?

Details:____

Yes No Female patients: Are you pregnant?

Details:____

Yes No Any other special problems not listed above?

Details:____