ADULT PATIENT INFORMATION

Date:________________
Your Name:____
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 Beautiful Smiles of NJ to release all information necessary to secure the payment of benefits. I assign directly to Beautiful Smiles of NJ 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:____________________

Dental History
General Dentist:____Date of last visit:___________
Address:____
City State Zip

Yes No Have you had previous orthodontic treatment? Describe:_________________________
Yes No Any injuries to teeth, mouth, or jaws? Describe:________________________________
Yes No Do you require antibiotics before teeth cleanings or other dental appointments?_________
Yes No Does your jaw ever click or get sore (TMJ/TMD)? If yes, when?____________________
Yes No Do you ever clench your teeth during?____
Yes No Do you grind your teeth?____
Yes No Do you ever have trouble opening your mouth as wide as you would like?_____________
Yes No Have you ever been informed of having any missing or extra permanent teeth?________
Yes No Have you ever lost or chipped any teeth?____
Yes No Is any part of your mouth sensitive to temperature? Where?_______________________
Yes No Is any part of your mouth sensitive to pressure? Where?__________________________
Yes No Have you ever seen a periodontist for periodontal treatment?______________________

Any other dental problems that we should know about?____

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

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

Abnormal bleeding/Hemophilia	Heart Surgery/Pacemaker
Allergies	Hemophilia
Anemia	Hepatitis
Artificial Bones/Joints/Valves	High / Low Blood Pressure
Arthritis	HIV+/AIDS
Asthma	Hospitalizations
Blood Transfusion	Kidney Problems
Congenital Heart Defect	Psychiatric Problems
Diabetes	Radiation Treatment
Drug/Alcohol Abuse	Rheumatic / Scarlet Fever
Emphysema	Severe / Frequent Headaches
Epilepsy/Seizures/Fainting	Shingles
Fever Blisters/Herpes	Sickle Cell Disease / Trait
Glaucoma	Sinus Problems
Heart Attack/Stroke	Tuberculosis (TB)
Heart Murmur	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?____
____
Yes No Have you ever taken Fosamax or any other bisphosphonate?______________________
Yes No Are you allergic to any medicine?____
Yes No Are you allergic to latex/metals/nickel/plastic?____________________________________
Yes No Do you smoke or chew tobacco?____
Yes No Female patients: Are you pregnant?____
Yes No Any other special problems not listed above?___________________________________