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1546 BLACKWOOD-CLEMENTON ROAD
BLACKWOOD, NJ 08012

adult registration & health history questionnaire

REFERRED BY: ____________________

LAST NAME, FIRST ____________________
STREET ADDRESS ____________________
CITY, STATE ZIP ____________________
HOME PHONE__________ WORK PHONE __________ CELL PHONE______
BIRTHDATE ____________________ SEX __________
SPOUSE'S NAME ____________________
DENTAL PLAN INFORMATION
HOLDER ____________________ RELATIONSHIP __________
SOCIAL SECURITY # ____________________
EMPLOYER ____________________
EMPLOYER ADDRESS____________________ PHONE __________
PRIMARY INSURANCE CO. ____________________
SECONDARY INSURANCE CO. ____________________
DEDUCTIBLE ____________________
GROUP # __________ LOCAL # __________ POLICY #__________
HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN SEEN IN THIS OFFICE?
____

NAME AND PHONE # OF SOMEONE TO CONTACT IN CASE OF EMERGENCY
____
____

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?
PLEASE LIST BELOW.
____
____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

- ☐ Local/Dental Anesthesia
- ☐ Aspirin
- ☐ Antibiotics
- ☐ Sulfa Drugs
- ☐ Pain Medication
- ☐ Penicillin
- ☐ Sedatives or Tranquilizers
- ☐ Others

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

- ☐ Chest Pain
- ☐ Ulcers
- ☐ Sinus Condition
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ AIDS
- ☐ Alcohol Addiction
- ☐ Drug Addiction
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Anemia
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Cirrhosis
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Artificial Replacements (Valves/Joints)
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Shortness of Breath
- ☐ Ankle Swelling
- ☐ High Blood Pressure
- ☐ Fainting Spells
- ☐ Epilepsy, Seizures Convulsions
- ☐ Other __________

Who is your physician? ____________________
Address ____________________
Are you under his/her care now? No _______ Yes _______
Explain: ____________________
Have you ever been hospitalized? No _______ Yes _______
Explain: ____________________
Have you ever had general anesthetic? No _______ Yes _______
Explain: ____________________
Were there any complications? No _______ Yes _______
Explain: ____________________
Have you ever had abnormal bleeding associated with previous extractions, surgery, or accidents? No _______ Yes _______
Explain: ____________________
If female, are you on oral contraceptives No _______ Yes _______
If female, are you pregnant? No _______ Yes _______
How long: ____________________
Have you ever had a blood transfusion? No _______ Yes _______
Explain: ____________________
Do you have a pacemaker? No _______ Yes _______
Explain: ____________________
Approximate date of last dental visit ____________________
Approximate date of last dental x-rays ____________________
Pharmacy Name & Number ____________________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card (MasterCard/Visa)

__________ ____________________
Date (today) Signature of Patient, or Parent, or Responsible Party.

NOTES