mydentistfriendnj.com
401 W Landis Ave
Vineland NJ, 08360
(856)500-8382

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Preferred Name _____ Birth Date _____ Age _____

SSN _____ Email _____

Address _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated

Home Phone # (_____)_____ Cell Phone # (_____)_____

Employer/School_____ Occupation _____

SPOUSE/PARENT INFORMATION

Last Name _____ First Name _____ MI _____

Relation to Patient _____ SSN _____

Birth Date _____ Age _____ Email _____

Home Phone # (_____)_____ Cell Phone # (_____)_____

☐ Same Address as the Patient

Address _____ City _____ State _____ Zip _____

Employer_____ Occupation _____

REFERRAL INFORMATION

How did you hear about our office?_____

Name of Referral _____

DENTAL INSURANCE INFORMATION (Primary):

Policyholder's Name _____ Birth Date _____ SSN _____

Insurance Company _____ Group Number _____

Employer _____ Policyholder's ID # _____

Patient Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other

DENTAL INSURANCE INFORMATION (Secondary):

Policyholder's Name _____ Birth Date _____ SSN _____

Insurance Company _____ Group Number _____

Employer _____ Policyholder's ID # _____

Patient Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other

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MEDICAL HISTORY

Are you under the care of a physician for any condition? If so, for what condition?

_____

Physician Name _____ Phone # (_____)_____

Has there been any change in your general health over the last year? _____

List any medications, prescription or over the counter:

_____

_____

Do you have any artificial joints? Which/when placed? _____

Do you use any tobacco products? ☐Yes ☐No If yes, what kind _____ How often _____

Check if you have or have had any of the following:

☐Anemia	☐Congenital Hearth Lesions	☐Hepatitis	☐Scarlet Fever
☐Arthritis, Rheumatism	☐Cortisone Treatments	☐Hernia Repair	☐Shortness of Breath
☐Artificial Heart Valves	☐Cough, Persistent	☐High Blood Pressure	☐Skin Rash
☐Artificial Joints, Pints, etc.	☐Cough up Blood	☐HIV/AIDS	☐Stroke
☐Asthma	☐Diabetes	☐Jaw Pain	☐Swelling of Feet or Ankles
☐Back Problems	☐Epilepsy	☐Kidney Disease	☐Thyroid Problems
☐Bleeding Abnormally	☐Fainting	☐Liver Disease	☐Tobacco Habit
☐Blood Disease	☐Glaucoma	☐Mitral Valve Prolapse	☐Tonsilitis
☐Cancer	☐Headaches	☐Pacemaker	☐Tuberculosis
☐Chemical Dependency	☐Heart Murmur	☐Radiation Treatment	☐Ulcer
☐Chemotherapy	☐Heart Problems	☐Respiratory Disease	☐Venereal Disease
☐Circulatory Problems	☐Hemophilia	☐Rheumatic Fever	

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Please list any allergies _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Check if you have any problems with any of the following:

☐Bad breath	☐Grinding teeth	☐Sensitivity
☐Bleeding gums	☐Loose teeth or broken fillings	☐Sores or growth in mouth
☐Clicking or popping jaw	☐Periodontal treatment	

AUTHORIZATION AND RELEASE

I _____ certify that to the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor
Patient/Parent/Guardian Name
child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to the doctors
Name of insurance company(ies)
operating in any capacity through My Dentist Friend, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dental practice and all dentists operating within their capacity may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by the Health Insurance Portability and Accountability Act (HIPAA), and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient.

_____ _____ _____

Signature of Patient, Parent, or Guardian | Print Name of Patient, Parent, or Guardian | Date