WELCOME TO TEANECK DENTIST

Name: FIRST NAME LAST NAME	Legal Name:	Date:
Address:		
City:	State:	Zip Code:
Home Phone:( )	Work Phone:( )	Cell Phone:( )
E-mail:	Date of Birth:	
Sex: Male ❑ Female ❑	Marital Status: S ❑ M ❑ D ❑ W ❑	Spouse's Name:
Social Security #:	F/T Student: Y ❑ N ❑	If YES, where?

Who is responsible for payment on this account?

Name:	Home Phone:( )
Address:	Work Phone:( )

City:	State:	Zip Code:	Social Security #:

In case of emergency, please notify:

Home Phone:( )	Work Phone:( )	Cell Phone:( )

DENTAL HISTORY

Reason for this visit:	Date of last dental exam:

❑ Teeth sensitive to hot, pressure or sweets	❑ Teeth chipped
❑ Bleeding gums	❑ Teeth too crowded
❑ Areas that catch food	❑ Smile has unattractive spaces
❑ Jaw pain	❑ Unattractive fillings or crowns
❑ Missing teeth	❑ Teeth too dark

MEDICAL HISTORY

Physician's Name:	Phone:
Address:	The date of your last physical exam:

Please mark with an "X" any condition which you have or have had in the past:

❑ Allergy to any drugs, metals, or latex.	❑ Asthma	❑ Sinus Problems
❑ Heart Ailment	❑ Hayfever	❑ Stroke/T.I.A
❑ High Blood Pressure	❑ Hepatitis	❑ Thyroid Problems
❑ Neurological Problems	❑ Malignancy	❑ Eye Problems
❑ Radiation Treatments	❑ Psychiatric Care	❑ Tuberculosis
❑ Bleeding Disorders, or Anemia	❑ Rheumatic Fever	❑ Ulcer/Colitis
❑ Arthritis	❑ Diabetes	❑ Sexually Transmitted Disease

❑ Aids, ARC, Exposure to Human Immunodeficiency Virus or high risk of exposure

❑ Prosthetic hip, knee or other joint or body part	❑ Osteoporosis	❑ Oral or IV drugs to treat osteoporosis

❑ Have you ever been advised by any physician or dentist that you should take an antibiotic prior to a dental visit?

Are you pregnant? ❑ Yes ❑ No	Due Date:	Are You nursing a baby? ❑ Yes ❑ No

Please list all medications that you are taking:

Please give details of any medical condition you have or have had:

Please Complete All Fields

Insurance Information

Primary Dental Insurance:	Secondary Dental Insurance:
Address:	Address:
Phone #:	Phone #:
Group #:	Group #:
Name of Insured:	Name of Insured:
DOB:	DOB:
Soc. Sec. #:	Soc. Sec. #:
Employer:	Employer:
Address:	Address:
Phone #:	Phone #:
Relation to Patient:	Relation to Patient:

Office Policy

Please read carefully and sign:

Emergencies: Our office is open 6 days and 2 evenings a week. When the office is closed, call 201-837-3000. You will be instructed regarding emergency care. A patient in pain will always be our top priority.

Appointments: We are proud to be an efficient and well run office. Please be punctual and reliable. We encourage you to demand the same of us. Same day cancellations, failures to show or lateness will be charged.

Payments: Payment is required in full at the end of each visit. For payment plans, formal arrangements must be made with the front desk. We accept Cash, Check, Visa, Mastercard and American Express Cards.

Insurance: Our advanced computer software will estimate your copay. Patients with Dental Insurance must pay the estimated copay at the end of each visit. Please remember that in the event of any delay in insurance payment, you will be held accountable for the prompt payment of your entire bill.

Signature of Person Responsible for Payment:_____Date:_____

Signature of Patient:_____ Date:_____

How did you hear about our office? ❑ Family/Friend (Name:_____)

❑ Verizon Yellowpages ❑ Superpages.com ❑ Google search ❑ Insurance company ❑ Ad In Record ❑ Jewish Standard ❑Suburbanite

❑ other newspaper ❑ Synagogue or Church Publication (Name:_____) ❑ Teaneck Shuls Inquiry

❑ 1-800-DENTIST ❑ I was referred by another dentist or physician (Name:_____) ❑ Ad in Parent Guide

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