Moorestown Smile Center
740 Marne Highway
Suit 106
Moorestown, NJ 08057
Ph # : 856-638-5266

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Student		SSN	
Email				School Name			
				Referral Type			

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? **No** **__ Yes __ No**

Group No/Name			
Insurance Name			
Phone #			
Employer Name			
Subscriber Last, First			
Subscriber Address			
City, State, Zip			
Relationship to Patient		Birth Date	
Subscriber ID			

Do you have Secondary Dental Insurance? **No** **__ Yes __ No**

Group No/Name			
Insurance Name			
Phone #			
Employer Name			
Subscriber Last, First			
Subscriber Address			
City, State, Zip			
Relationship to Patient		Birth Date	
Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals

- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis

- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur

- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash

- [ ] Y [ ] N No Epinephrine
- [ ] Y [ ] N Penicillin
- [ ] Y [ ] N Prior Hepatitis
- [ ] Y [ ] N Sulfa Drugs
- [ ] Y [ ] N Other Narcotics

Check, if applicable

- [ ] Y [ ] N No Change Since Last Recorded
- [ ] Y [ ] N No Known Concerns or Issues
- [ ] Y [ ] N Abnormal Bleeding
- [ ] Y [ ] N AIDS/HIV Infection
- [ ] Y [ ] N Alcohol/Drug Abuse
- [ ] Y [ ] N Angina
- [ ] Y [ ] N Anemia
- [ ] Y [ ] N Ankles Swell
- [ ] Y [ ] N Cancer / Tumor or Growth
- [ ] Y [ ] N Cardiac Pacemaker
- [ ] Y [ ] N Cardiovascular Disease
- [ ] Y [ ] N Chemotherapy
- [ ] Y [ ] N Chest Pain Upon Exertion
- [ ] Y [ ] N Color Blindness
- [ ] Y [ ] N Congenital Heart Defect
- [ ] Y [ ] N Contact Lenses
- [ ] Y [ ] N Congestive Heart Failure
- [ ] Y [ ] N Damaged Heart Valve
- [ ] Y [ ] N Diabetes
- [ ] Y [ ] N Emphysema
- [ ] Y [ ] N Environmental Allergies
- [ ] Y [ ] N Epilepsy
- [ ] Y [ ] N Hepatitis
- [ ] Y [ ] N Herpes
- [ ] Y [ ] N High Blood Pressure
- [ ] Y [ ] N Hives
- [ ] Y [ ] N Jaundice
- [ ] Y [ ] N Joint Replacement
- [ ] Y [ ] N Kidney
- [ ] Y [ ] N Leukemia
- [ ] Y [ ] N Liver Disease
- [ ] Y [ ] N Low Blood Pressure
- [ ] Y [ ] N Lupus
- [ ] Y [ ] N Mental Health Problems
- [ ] Y [ ] N Mitral Valve Prolapse
- [ ] Y [ ] N Pacemaker
- [ ] Y [ ] N Sinus Trouble
- [ ] Y [ ] N Stomach Ulcers
- [ ] Y [ ] N Stroke
- [ ] Y [ ] N Thyroid Problems
- [ ] Y [ ] N Tuberculosis
- [ ] Y [ ] N Unusual Weight Loss
- [ ] Y [ ] N Urinate Frequently

Other

- [ ] Y [ ] N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ?

Have you had any head, neck or jaw injuries ?

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment ?

If Yes, date of placement

Do you wear dentures or partials ?

If Yes, date of placement of dentures ?

Are you happy with your dentures ?

Are you having any specific problems with your teeth, gums, or mouth at this time ?

Are you happy with your smile ?

Do you have problems with teeth/fillings breaking ?

Do you regularly use dental floss ?

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ?

Do you have difficulty in opening your mouth widely ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Does food catch between your teeth ?

Do you want to learn to control your dental disease and retain your teeth ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? _____

If Yes, what ? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Have you ever taken the diet control drug Fen-Phen ? _____

Do you use alcoholic beverages ? _____

Do you smoke ? _____

Women Only

Are you pregnant?	
If Yes, what is your due date ?	
Are you currently nursing ?	
Do you have menstrual period problems ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**