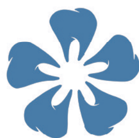

# Ohana Dental

30 Prospect Street
Midland Park, New Jersey 07432

## PATIENT INFORMATION

Date ______________________ Home Phone ______________________

Name ______________________ Soc. Sec. ______________________
Last Name First Name Initial

Address ______________________

City ______________________ State ______________________ Zip ______________________

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By ______________________ Occupation ______________________

Business Address ______________________ Business Phone ______________________

Whom may we thank for referring you? ______________________

In case of emergency, who should be notified?

## PRIMARY INSURANCE

Person Responsible for Account ______________________

Relation to Patient ______________________ Birthdate ______________________ Soc. Sec. # ______________________

Address (if different from patient's) ______________________ Phone ______________________

City ______________________ State ______________________ Zip ______________________

Person Responsible Employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone ______________________

Insurance Company ______________________

Contract # ______________________ Group ______________________ Subscriber ______________________

Names of other dependents covered under this plan

## ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________ Relation to Patient ______________________ Birthdate ______________________

Address (if different from patient's) ______________________ Phone ______________________

City ______________________ State ______________________ Zip ______________________

Subscriber Employed by ______________________ Business Phone ______________________

Insurance Company ______________________ Soc. Sec. ______________________

Contract # ______________________ Group ______________________ Subscriber ______________________

Name of other dependents covered under this plan ______________________

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with______________________

and assign directly to Ohana Dental 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________________________

Responsible Party Signature Relationship Date

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

# DENTAL HEALTH HISTORY
## (CONFIDENTIAL)

## DENTAL HISTORY

Today's Date

Patient Name ______ Birthdate

Last Name First Name Initial

Reason for Today's Visit

Former Dentist

Address

Date of last dental care ______ Date of last dental X-rays

Check ( ✔ ) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Snoring
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth

Are you happy with the appearance of your teeth? ☐ Yes ☐ No If no, Why? ______

How often do you floss? ______ How often do you brush?

## MEDICAL HISTORY

Physician's Name ______ Date of last visit

Have you had any serious illnesses or operations? If yes, describe

Have you ever been told to take a pre-medication before dental treatment? ☐ Yes ☐ No

Have you ever taken Osteoperosis (low bone density) medications/bisphosphonates? ☐ Yes ☐ No

WOMEN: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check ( ✔ ) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problem
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Dialysis
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems

Describe:

- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

## MEDICATIONS

List medications you are currently taking:

______

______

Pharmacy Name

Phone

## ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______

______

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ______ Signature

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**