Welcome

Bergenline Family Dental

<table>
<tr><th colspan="8">PATIENT INFORMATION</th></tr>
<tr><td colspan="2">Patient's Last Name:</td><td>First:</td><td>Middle:</td><td>❑ Mr.
❑ Mrs.</td><td>❑ Miss
❑ Ms.</td><td colspan="2">Marital status (circle one)
Single / Mar / Div / Sep / Wid</td></tr>
<tr><td colspan="2">Is this your legal name?
❑ Yes ❑ No</td><td>If not, what is your legal name?</td><td colspan="2">(Former name):</td><td>Birth date:</td><td>Age:</td><td>Sex:
❑ M ❑ F</td></tr>
<tr><td colspan="3">Street address:</td><td colspan="3">Social Security No.:</td><td colspan="2">Home Phone No.:
( )</td></tr>
<tr><td>City:</td><td colspan="3">State:</td><td colspan="2">ZIP Code:</td><td colspan="2">Cell Phone No. :
( )</td></tr>
<tr><td>Occupation:</td><td colspan="5">Employer:</td><td colspan="2">Employer Phone No.:
( )</td></tr>
<tr><td colspan="3">Referred to clinic by (please check one box):</td><td>❑ Dr.</td><td colspan="2">❑ Insurance Plan</td><td colspan="2">❑ Hospital</td></tr>
<tr><td>❑ Family</td><td>❑ Friend</td><td>❑ Close to home/work</td><td>❑ Yellow Pages</td><td colspan="2">❑ Other</td><td colspan="2"></td></tr>
</table>

<table>
<tr><th colspan="6">INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)</th></tr>
<tr><td>Subscriber's Name:</td><td>Subscriber SSN:</td><td>Birth Date:</td><td>ID No.:</td><td>Group No.:</td><td>Effective Date:</td></tr>
<tr><td>Patient's relationship to subscriber:</td><td>❑ Self</td><td>❑ Spouse</td><td>❑ Child</td><td>❑ Other</td><td></td></tr>
<tr><td>Name of secondary insurance (if applicable):</td><td colspan="3">Subscriber's name:</td><td>ID No.:</td><td>Group No.:</td></tr>
<tr><td>Patient's relationship to subscriber:</td><td>❑ Self</td><td>❑ Spouse</td><td>❑ Child</td><td>❑ Other</td><td></td></tr>
</table>

DENTAL HISTORY		
Why have you come to the dentist today?		
Do you require antibiotics before dental treatment?	❑ Yes	❑ No
Are you currently in pain?	❑ Yes	❑ No
Have you ever had a serious problem associated with any previous dental work?	❑ Yes	❑ No
Have you ever had gum treatment?	❑ Yes	❑ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?	❑ Yes	❑ No
Do your gums ever bleed?	❑ Yes	❑ No
How many times a week do you floss?		
How many times a day do you brush?		
Are your teeth sensitive to heat, cold, or anything else?	❑ Yes	❑ No

CONTINUED ON BACK »

MEDICAL HISTORY			
Have you ever had any of the following diseases or medical problems? (Please Circle All That Apply)			
Abnormal Bleeding	Emphysema	High Blood Pressure	Rheumatic / Scarlet Fever
Alcohol/Drug Abuse	Epilepsy	HIV / AIDS	Seizures
Anemia	Fainting Spells	Hospitalized for Any Reason	Shingles
Arthritis	Frequent Headaches	Kidney Problems	Sickle Cell Disease / Traits
Artificial Bones/Joints/Valves	Glaucoma	Liver Disease	Sinus Problems
Asthma	Hay Fever	Low Blood Pressure	Stroke
Blood Transfusion	Heart Attack	Lupus	Thyroid Problems
Cancer/Chemotherapy	Heart Murmur	Mitral Valve Prolapse	Tuberculosis (TB)
Colitis	Heart Surgery	Osteoporosis / Paget's Disease	Ulcers
Congenital Heart Defect	Hemophilia	Pacemaker	Venereal Disease
Diabetes	Hepatitis	Psychiatric Problems	
Difficulty Breathing	Herpes/ Fever Blisters	Radiation Treatment	

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following? (Please Circle All That Apply)		
Aspirin	Erythromycin	Tetracycline
Codeine	Latex	Other: ____________________
Dental Anesthetics	Penicillin	

Are you taking any medication?	❑ Yes	❑ No
Please list any medications that you are currently taking:		

IN CASE OF EMERGENCY			
Name of Emergency Contacts:	Relationship to patient:	Home Phone No.:	Work Phone No.:
		( )	( )
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bergenline Family Dental or insurance company to release any information required to process my claims.

Signature:	***Date:***

Payment is due in full at the time of treatment (unless prior arrangements have been approved). I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Bergenline Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Signature:	***Date:***