Klockner Road Office, 2929 Klockner Road, Hamilton Square, NJ 08690 (609) 586-6603
Kuser Road Office, NJ Family Care, 2501 Kuser Road (2nd Floor), Hamilton Township, NJ 08691 (609) 689-1212

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ / _____ / _____ SSN: _____ Gender: ☐ M ☐ F

Marital Status: Single Married Separated Divorced Widowed

HEALTH INFORMATION

Date of Last Dental Exam: _____ X-rays Taken: ☐ Y ☐ N Reason for Visit: _____

Have you ever had any of the following? Please circle Yes or No.

ADD/ADHD	Y	N	Down Syndrome	Y	N	High Blood Pressure	Y	N	Radiation Treatment	Y	N
AIDS/HIV Positive	Y	N	Drug Addiction	Y	N	Hypoglycemia	Y	N	Respiratory Problems	Y	N
Allergies	Y	N	History of Endocarditis:			Jaundice	Y	N	Rheumatic Fever	Y	N
ANxiety/Panic	Y	N	(Heart Infection)	Y	N	Irregular Heartbeat	Y	N	Rheumatism	Y	N
Asthma	Y	N	Epilepsy or Seizures	Y	N	Joint Replacements:			Sinus Problems	Y	N
Autism	Y	N	Excessive Bleeding	Y	N	(Hip, Knee)	Y	N	Sjogren's Syndrome	Y	N
Blood Disease	Y	N	Fainting Bleeding	Y	N	Kidney Problems	Y	N	Stomach Problems	Y	N
Cancer	Y	N	Glaucoma	Y	N	Leukemia	Y	N	Stroke	Y	N
Chemotherapy	Y	N	Head Injuries	Y	N	Liver Disease	Y	N	Thyroid Disease	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Disease	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Congenital Heart Disorder	Y	N	Heart Murmur	Y	N	Mental Disorders	Y	N	Tumors or Growths	Y	N
Convulsions	Y	N	Hepatitis A	Y	N	Nervous Disorders	Y	N	Valve Replcements	Y	N
Developmentally Delayed	Y	N	Hepatitis B or C	Y	N	Pain in Jaw Joints	Y	N	Other	Y	N
Diabetes	Y	N	Herpes	Y	N	Pregnancy	Y	N			

If you answered yes, please explain: _____

Please list any serious illness not listed above: _____

Are you happy with your smile? _____If not, why? _____

Do you have any drug allergies? ☐ Y ☐ N If yes, please explain: _____

List any medication(s) you are currently taking: _____

Have you ever had any complications following dental treatment: ☐ Y ☐ N

If yes, please explain: _____

Have you ever had any of the following habits?

☐ Lip Sucking/Biting ☐ Nail Biting ☐ Nursing/Bottle Habits ☐ Thumb/Finger Sucking

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Y ☐ N

If yes, please explain: _____

Do you have any health problems that need further clarification? ☐ Y ☐ N

If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct.
If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date: _____