New Patient Information

NAME _____

HOME NUMBER _____

WORK NUMBER _____

CELL NUMBER _____

In case of emergency, please contact: _____

Relationship to patient: _____

Emergency contact number: _____

EMAIL _____

Please circle if you are currently taking, or have **ever** taken, one of the following medications:

ORAL	INTRAVENOUSLY
Actonel	Aredia
Boniva	Zometa
Fosamax	Bonefos
Fosamax Plus D	Reclast Therapy
Skelid	Xgeva
Didronel	Pamidronate
Risedronate	Zolendronic Acid
Ibandronate	Clodronate
Alendronate	Denosumab
Tiludronate	Prolia
Etidronate	

If yes, please give dates and duration: _____

CONFIDENTIAL HEALTH HISTORY

Name_____ Home Phone (___)_____

Address_____ City_____ State _____ Zip Code_____

Date of Birth _____ Age _____ Height _____ Weight _____ Sex ☐ M ☐ F

DENTAL INFORMATION

Do your gums bleed when you brush?	☐ yes	☐ no	☐ sometimes
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐ yes	☐ no	☐ sometimes
Do you have headaches, earaches or neck pains?	☐ yes	☐ no	☐ sometimes
Have you ever had orthodontic (braces) treatment?	☐ yes	☐ no	
Have you ever had periodontal (gum) treatment?	☐ yes	☐ no	
Do you wear removable dental appliances?	☐ yes	☐ no	

Have you had a serious/difficult problem associated with any previous dental treatment? ☐ yes ☐ no

If so, explain _____

Who was your previous dentist? _____

Date of your last dental exam _____ Date of last dental x-rays _____ Date of last dental cleaning _____

Describe your current dental problem _____

_____

What improvements would you like to see in your smile? _____

MEDICAL INFORMATION

Physician (s) names _____ Phone number _____

Preferred pharmacy _____ Phone number _____

Describe your overall health condition? _____ Has it changed within the past year? ☐ yes ☐ no

Are you under the care of a physician? ☐ yes ☐ no If so, for what condition? _____

Please list ALL medications you are currently taking (include prescription and non-prescription and daily dosages) _____

_____

_____

_____

_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? ☐ yes ☐ no

If so, what was the illness or problem? _____

Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? ☐ yes ☐ no

Do you drink alcoholic beverages? ☐ yes ☐ no ☐ sometimes Approximately how much in the last 24 hours? _____

Do you use drugs/other substances for recreational purposes? ☐ yes ☐ no What have you used in the last 24 hours? _____

Do you use tobacco (smoking, snuff, chew)? ☐ yes ☐ no ☐sometimes Approximately how much in an average day? _____

Do you wear contact lenses? ☐ yes ☐ no

Do you have any of the following diseases or problems?	Active tuberculosis?	☐ yes	☐ no
	Persistent cough greater than a 3-week duration?	☐ yes	☐ no
	Cough that produces blood?	☐ yes	☐ no

Have you had an orthopedic total joint replacement? ☐ yes ☐ no Which joint? _____ When? _____

Have you had an complications with your prosthetic joint? ☐ yes ☐ no If so, explain _____

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ yes ☐ no

If so, what antibiotic and dose? _____

WOMEN: Are you pregnant? ☐ yes ☐ no ☐ don't know

Nursing? ☐ yes ☐ no

Taking birth control pills? ☐ yes ☐ no

(CONTINUED ON REVERSE SIDE)

ALLERGIES

Please (X) if you are allergic to or have had a reaction to:

_____ Local anesthetics
_____ Aspirin
_____ Penicillin or other antibiotics
_____ Latex
_____ Sulfa drugs
_____ Codeine or other narcotics
_____ Barbiturates, sedatives or sleeping pills
_____ Iodine
_____ Hay fever/seasonal
_____ Animals
_____ Food (Specify)_____
_____ Other _____

To the yes responses, specify type of reaction_____

PLEASE (X) IF YOU HAVE OR HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

_____ Abnormal bleeding
_____ AIDS or HIV infection
_____ Anemia
_____ Arthritis
_____ Rheumatoid Arthritis
_____ Asthma
_____ Blood transfusion
If yes, date_____
_____ Cancer/chemotherapy/radiation
If yes, specify_____
_____ Cardiovascular disease
If yes, specify
_____ Angina
_____ Arteriosclerosis
_____ Artificial heart valve
_____ Coronary insufficiency
_____ Coronary occlusion
_____ Damaged heart valves
_____ Heart attack
_____ Heart murmur
_____ High blood pressure
_____ Inborn heart defects
_____ Mitral valve prolapse
_____ Pacemaker
_____ Rheumatic heart disease
_____ Chest pain upon exertion
_____ Chronic pain
_____ Persistent diarrhea
_____ Disease, drug, or radiation-induced immunosurpression
_____ Diabetes. If yes, specify
_____ Type I (insulin dependent)
_____ Type II
_____ Dry mouth
_____ Eating disorder
If yes, specify _____
_____ Epilepsy
_____ Fainting spells or seizures
_____ G.E. Reflux
_____ Glaucoma
_____ Hemophilia
_____ Hepatitis, jaundice or liver disease
_____ Recurrent infections
If yes, specify type of infection _____
_____ Kidney problems
_____ Low blood pressure
_____ Lyme disease
_____ Mental health disorders
If yes, specify _____
_____ Malnutrition
_____ Migraines
_____ Night sweats
_____ Neurological disorders
If yes, specify _____
_____ Osteoporosis
_____ Persistent swollen glands in neck
_____ Respiratory problems. If yes, specify
_____ Emphysema
_____ Bronchitis, etc.
_____ Scarlet fever
_____ Severe headaches
_____ Severe or rapid weight loss
_____ Sexually transmitted disease
_____ Sinus trouble
_____ Sleep disorder
_____ Sores or ulcers in the mouth
_____ Stroke
_____ Systemic lupus erythematosus
_____ Thyroid problems
_____ Tuberculosis
_____ Ulcers
_____ Excess urination

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ yes ☐ no
Explanation/Comments: _____

_____

_____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature:_____ Date:_____

REGISTRATION
(PLEASE PRINT)

Maria Maiorino, D.M.D.
General & Cosmetic Dentistry

Date_____ Home Phone_____

PATIENT INFORMATION

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_____ Phone_____

Whom may we thank for referring you?_____

Emergency Contact_____ Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name *First Name* *Initial*

Relationship to Patient_____ Birthdate_____ Soc.Sec.#_____

Address (*if different than Patient)*_____ Phone_____

City_____ State_____ Zip_____

Responsible Person Employed by_____ Occupation_____

Business Address_____ Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Other Dependent Names under this plan_____

ADDITIONAL INSURANCE *(if any)*

Subscriber Name_____ Relationship to Patient_____ Birthdate_____

Address (*if different than Patient)*_____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Phone_____

Insurance Company_____ Soc.Sec.#_____

Contract #_____ Group #_____ Subscriber #_____

Other Dependent Names under this plan_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with (insurance companies names)_____

_____

and assign directly to Columbus Dental Arts LLC 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*

Columbus Dental Arts

Dear Patient,

One of the most important services we provide is the periodic exam and prophylaxis. During your recare appointment we do some or all of the following:

Medical history update
Oral cancer screening
Radiographic screening
Cavity detection
Desensitizing therapy
Fluoride treatment
Antibacterial irrigation
Dental cleaning
Oral hygiene instructions

In order to perform these services properly, we allow 40 to 60 minutes in our schedule exclusively for you. We require a 48 hour notice to change or cancel your appointment. In an effort to control escalating costs and continue to provide outstanding and thorough service, we have the following policy:

Same day cancellation-Less than 24 hrs. notice $50.00
Missed appointment- No show $75.00

We look forward to developing a positive relationship.

Sincerely,

Dr. Maria Maiorino Maria Maiorino, DMD

Signature

23203 Columbus Road, Suite Q Columbus, NJ 08022 609-324-9500 Fax 609-324-9002

MARIA BRUNI MAIORINO, D.M.D.

General & Cosmetic Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____ *Individual refused to sign*
- _____ *Communication barriers prohibited obtaining the acknowledgement*
- _____ *An emergency situation prevented us from obtaining acknowledgement*
- _____*Other (please specify)*

  _____

  _____

  _____