WELCOME

Please take a few minutes to fill out this form. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

1 PATIENT INFORMATION

Preferred Name _____

Patient: Mr., Mrs., Ms., Miss, _____
First Initial Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone_____

Email Address _____

Gender: M _____ F _____ Marital Status: Single _____ Married _____ Other _____

Social Security Number _____ Birthdate _____

Occupation _____ Employer _____ Work Phone _____

Work Address _____
Street City State Zip

Spouse's Name _____Spouse's Work Phone _____

Emergency Contact Phone Number (Home) _____ Emergency Contact Phone Number (Cell) _____

Please tell us how you found our office (Optional) _____

2 DENTAL HISTORY

Please place a mark on the "Yes" or "No box next to each item to indicate if you have had any of the following conditions:

Yes	No		Yes	No		Yes	No	
❑	❑	Bad Breath (Halitosis)	❑	❑	Loose Teeth	❑	❑	Smokeless Tobacco Habit
❑	❑	Bleeding Gums	❑	❑	Missing Teeth	❑	❑	Smoking Habit
❑	❑	Blisters on Lips or in Mouth	❑	❑	Mouth Breathing	❑	❑	Snoring/Sleep Apnea
❑	❑	Broken or Chipped Teeth	❑	❑	Orthodontic Treatment (Braces)	❑	❑	Sores in Your Mouth
❑	❑	Burning Sensation in Mouth	❑	❑	Periodontal (Gum) Treatment	❑	❑	Spaces Between Teeth
❑	❑	Clicking or Popping in Jaw Joint	❑	❑	Sensitive Teeth/Gums	❑	❑	Stains on Teeth
❑	❑	Dark Teeth	❑	❑	to Biting/Chewing	❑	❑	Swollen or Tender Gums
❑	❑	Dry Mouth	❑	❑	to Brushing	❑	❑	Teeth Moving
❑	❑	Grinding or Clenching Teeth	❑	❑	to Cold	❑	❑	TMD/TMJ Treatment
❑	❑	Headaches	❑	❑	to Heat	❑	❑	Trauma or Injury to Teeth,
❑	❑	Jaw or Joint Pain	❑	❑	to Sweets	❑	❑	Jaws or Face

Date of last dental visit _____

Do you have any concerns about your teeth or mouth? _____

Is there anything you would like to change about the appearance of your teeth? _____

PLEASE COMPLETE OTHER SIDE

JEFFREY S. CHRISTOPHER, DDS, MAGD
600 River Road • Fair Haven, NJ 07704
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3 HEALTH HISTORY

Please place a mark on the "Yes" or "No" box next to each item to indicate if you have had any of the following conditions:

Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Heart Murmur	❑	❑	Scarlet Fever
❑	❑	Angina (chest pain)	❑	❑	Heart Problem	❑	❑	Shortness of Breath
❑	❑	Arthritis, Rheumatism	❑	❑	Heart Valve Replacement	❑	❑	Sinus Problem
❑	❑	Asthma	❑	❑	Hepatitis, type _____	❑	❑	Skin Rash
❑	❑	Back Pain	❑	❑	Herpes	❑	❑	Stroke or TIA
❑	❑	Bleeding Problem	❑	❑	High Blood Pressure	❑	❑	Surgery
❑	❑	Blood Disease	❑	❑	HIV/AIDS	❑	❑	Swelling of Feet or Ankles
❑	❑	Cancer	❑	❑	Jaundice	❑	❑	Swollen Neck Gland
❑	❑	Chemical Dependency	❑	❑	Jaw Pain	❑	❑	Thyroid Problem
❑	❑	Chemotherapy	❑	❑	Joint Replacement	❑	❑	Tuberculosis
❑	❑	Circulatory Problem	❑	❑	Kidney Disease	❑	❑	Tobacco Habit,
❑	❑	Congenital Heart Disorder	❑	❑	Liver Disease	❑	❑	Tumor
❑	❑	Cortisone Treatment	❑	❑	Low Blood Pressure	❑	❑	Ulcer
❑	❑	Coughing	❑	❑	Mitral Valve Prolapse	❑	❑	Venereal Disease
❑	❑	Diabetes	❑	❑	Nervous Problem	❑	❑	Weight Loss or Gain
❑	❑	Emphysema	❑	❑	Pacemaker			Women:
❑	❑	Epilepsy	❑	❑	Psychiatric Care	❑	❑	Are you pregnant?
❑	❑	Fainting or Dizziness	❑	❑	Radiation Treatment			Due Date _____
❑	❑	Glaucoma	❑	❑	Respiratory Problem	❑	❑	Are you nursing?
❑	❑	Headaches	❑	❑	Rheumatic Fever	❑	❑	Do you take birth control pills?

Primary Physician _____ **Phone** _____ **Date of Last Visit** _____

4 ALLERGIES

Please place a mark on the "Yes" or "No" box next to each item to indicate if you have had an allergic reaction to any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Antibiotics	❑	❑	Codeine	❑	❑	Local Anesthetic
❑	❑	Aspirin	❑	❑	Latex	❑	❑	Penicillin

❑ ❑ Other (Please Explain) _____

5 MEDICATIONS

Please list all of the prescription medications you are currently taking with the dosages if you know them.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any over-the-counter medications, vitamins, dietary or herbal supplements, etc. that you are taking.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Pharmacy Name _____ **Phone** _____

6 AUTHORIZATION

The information I have given is correct to the best of my knowledge. I understand that it is my duty to inform this office of any change in my health or medical status and that such changes may effect my dental care.

I understand that I am financially responsible for all charges and that payment in full is expected at the time of treatment unless prior financial arrangements have been made. I recognize that any dental insurance coverage I have is a separate arrangement between me and a third party who may or may not reimburse a portion of my expenses.

Signature _____ Date _____

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