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Welcome to Bedminster Family Dental

Chart#: _____

FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First ___ MI

_____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____

Best time to call: _____

Phone: _____ Home _____ Mobile _____ Work _____ Ext

_____ Fax _____ Other

Address: _____ Address 1

_____ Address 2

_____ City _____ State _____-____ Zip Code

Emergency contact name _____

Emergency contact phone number _____

Whom may we thank for referring you to our practice?

_____

Employer Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____
Address 1

_____
Address 2

_____
City

_____ _____-____
State Zip Code

Responsible Party Information:

This only need to be filled out if the insurance subscriber is other than the patient, or if the patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ____
Last First MI

_____
Preferred Name

Title: _____ **Gender:** _____ ◯ Male ◯ Female
Mr/Ms/Mrs/etc

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: _____ **DL#:** ___-__-____

Email Address: _____

Best time to call: _____

Phone: _____ _____ _____ _____
Home Mobile Work Ext

_____ _____
Fax Other

Address: _____
Address 1

_____
Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Medical Infomation

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- [ ] *Heart Murmur-PreMed
- [ ] *MEDS
- [ ] *MVP
- [ ] *No-EPI
- [ ] *PRE-MED-Amoxicillin
- [ ] *PRE-MED-Clindamycin
- [ ] *Pre-Med-Other
- [ ] AFIB
- [ ] Allergic to Oragel
- [ ] Allergic-Benzocaine
- [ ] ALLERGY TO IODINE
- [ ] Allergy-Aspirin
- [ ] Allergy-Codeine
- [ ] Allergy-Erythromycin
- [ ] Allergy-Foods
- [ ] Allergy-Latex
- [ ] Allergy-Other Meds
- [ ] Allergy-Penicillin
- [ ] Allergy-Sulfa
- [ ] Allergy-Tetracycline
- [ ] amoxicillin
- [ ] Anemia
- [ ] anxiety
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] augmentin
- [ ] Blood Disease
- [ ] Blood Thinners
- [ ] camphor
- [ ] Cancer
- [ ] chlorohexidine rinse
- [ ] Codine
- [ ] Diabetes
- [ ] Dizziness
- [ ] Do Not Recline
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Fosomax
- [ ] Head Injuries
- [ ] Heart Bypass
- [ ] Heart Disease
- [ ] Heart Murmur-No Med
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] high cholesterol
- [ ] Iodine
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] latex
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lymes Disease
- [ ] milk products
- [ ] morphine
- [ ] Multiple Scerosis
- [ ] Naprosyn/anti-inflam
- [ ] No Cavitron
- [ ] No Pre-Med
- [ ] No topical
- [ ] On Birth Control
- [ ] On Coumadin
- [ ] OSTEOPEROSIS
- [ ] Pacemaker
- [ ] PECANS
- [ ] penicillin
- [ ] PRE- MED -KEFLEX
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Risk Type P
- [ ] See Chart
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid
- [ ] TMJ
- [ ] tree nuts
- [ ] Trigeminal Neuralgia
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Use N2o
- [ ] wellbutrin

other _____

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

- [ ] **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Name of patient, parent, or guardian completing this form:

_____

_____

_____

Response Date: _____