DUMONT FAMILY DENTAL

Dr. Christopher Restieri, 110-C West Shore Avenue, Dumont, NJ 07628

INTAKE FORM **Date**_____

PATIENT INFORMATION

Name_____ SS#_____

Address_____ City_____ State____ Zip_____

Age_____ Date of Birth____/____/____ Marital Status: ☐Single ☐Married ☐Divorced ☐Separated

Home Ph_____ Work Ph_____ Cell Ph_____

Occupation_____ Employer_____

Employer Address_____ City_____ State____ Zip_____

Name of Spouse_____ Spouses Date of Birth____/____/____

If Patient is a Student – Name of School/College_____

Whom May We Thank For Referring You?_____

RESPONSIBLE PARTY

Name of Person Responsible for the Account_____

Address_____ City_____ State____ Zip_____

Relation to Patient_____ Home Ph_____ Work Ph_____

INSURANCE INFORMATION

Dental Insurance: ☐Yes ☐No **Company**_____

PLEASE PRESENT YOUR INSURANCE CARD *SO THAT WE MAY HAVE A COPY ON FILE*

Name of Insured_____ Date of Birth____/____/____ SS#_____

Relation to Insured: ☐Self ☐Spouse ☐Child ☐Other

How much is your Deductible?_____ How much have you used?_____

Maximum Annual Benefit_____

SECONDARY INSURANCE

Name of Insured_____ Date of Birth____/____/____

Relation of Insured: ☐Self ☐Spouse ☐Child ☐Other

How much is your Deductible?_____ *How much have you used?*_____

Maximum Annual Benefit_____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address_____ City_____ State____ Zip_____

Date of Last Dental Visit ____/____/____ **Date of Last Dental X-rays** ____/____/____

How often do you floss? _____ **How often do you brush?** _____

Check All That Apply:

☐bad breath	☐grinding teeth	☐sensitivity to heat
☐bleeding gums	☐loose teeth or broken fillings	☐sensitivity to sweets
☐clicking or popping jaw	☐periodontal treatment	☐sensitivity when biting
☐food collection between teeth	☐sores or growths in your mouth	☐sensitivity to cold

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit ____/____/____

Have you had any serious illnesses or operations? ☐Yes ☐No
If yes, please list what and approximate dates _____

Have you ever had a blood transfusion? ☐Yes ☐No
If yes, please list approximate dates _____

Are you Pregnant? ☐Yes ☐No **Nursing?** ☐Yes ☐No **Taking birth control pills?** ☐Yes ☐No

Check All That Apply:

☐AIDs	☐Cortisone treatments	☐Hepatitis	☐Rheumatic fever
☐Anemia	☐Cough, persistent	☐High blood pressure	☐Scarlet fever
☐Arthritis, Rheumatism	☐Cough up blood	☐HIV positive	☐Shortness of Breath
☐Artificial heart valves	☐Diabetes	☐Jaw pain	☐Skin rash
☐Artificial joints	☐Epilepsy	☐Kidney disease	☐Stroke
☐Asthma	☐Fainting	☐Liver Disease	☐Swelling of feet or ankles
☐Back problems	☐Glaucoma	☐Mitral valve prolapse	☐Thyroid problems
☐Blood disease	☐Headaches	☐Nervous problems	☐Tobacco habit
☐Cancer	☐Heart murmur	☐Pacemaker	☐Tonsillitis
☐Chemical dependency	☐Heart problems	☐Psychiatric care	☐Tuberculosis
☐Chemotherapy	Describe_____	☐Radiation treatment	☐Ulcers
☐Circulatory problems	☐Hemophilia	☐Respiratory disease	☐Venereal disease

MEDICATIONS: PLEASE LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKING

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: MEDICATION, FOOD SEASONAL

_____ _____

_____ _____

AUTORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient or Parent if a Minor **Date**

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED