Dumont Family Dental
Dr. Christopher J. Restieri 110 West Shore Ave . Dumont NJ . 07628 201.384.9519

CHECK ALL THAT APPLY:

___ bad breath
___ bleeding gums
___ clicking or popping jaw
___ food collection between teeth
___ grinding teeth
___ loose teeth
___ periodontal treatment
___ broken fillings
___ sensitivity to heat
___ sensitivity to sweets
___ sensitivity to biting
___ sensitivity to cold

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____/_____/_____

Have you had any serious illness or operations? Yes_____ No_____

If Yes, please list what and the approximate dates:_____

_____

Are you pregnant? Yes_____ No_____ Are you nursing? Yes_____ No_____

CHECK ALL THAT APPLY:

___ AIDS
___ Anemia
___ Arthritis
___ artificial joints
___ Asthma
___ back pain
___ blood disease
___ cancer
___ chemotherapy
___ Cortisone treatment
___ cough (persistent)
___ coughing up blood
___ Diabetes
___ Epilepsy
___ Glaucoma
___ headaches
___ heart murmur
___ heart disease
___ Hemophilia
___ Hepatitis
___ high blood pressure
___ HIV positive
___ jaw pain
___ kidney disease or ulcers
___ liver disease
___ Mitral Valve Prolapse
___ nervous problems
___ pacemaker
___ radiation treatment
___ respiratory disease
___ Rheumatic Fever
___ Scarlet Fever
___ shortness of breath
___ skin rash
___ stroke
___ swelling of ankles
___ Thyroid problems
___ tobacco habit
___ Tuberculosis

MEDICATIONS:

_____ _____ _____

_____ _____ _____

ALLERGIES:

_____ _____ _____

_____ _____ _____

AUTHORIZATION 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 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.

Patient Signature: _____ Date:____/____/_____