Patient Information

2003 Washington Valley Rd. Martinsville, NJ 08836
Tel: 732.377.9690
www.MartinsvilleDentistry.com

Welcome to *Park Dental of Martinsville*! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient Name: _____
First Middle Last

I prefer to be called: Mr. Mrs. Ms. Nickname _____ Birth Date: _____/_____/ ____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ May we text you? ☐Yes / ☐No

Email: _____ Social Security #: _____-_____-_____ (for insurance submission)

Occupation: _____ Employer: _____

Emergency Contact Person: _____ Phone: _____ Relationship: _____

How did you hear about our office? ☐Internet Search / ☐Mailer / ☐Printed Ad / ☐Referral / Other _____

-Whom may we thank for referring you? _____

Primary Insurance	**Secondary Insurance**
Insurance Company: _____	Insurance Company: _____
Plan ID #: _____	Plan ID #: _____
Group #: _____	Group #: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
DOB: ___ / ___ / ____ Social: _____-____-_____	DOB: ___ / ___ / ____ Social: _____-____-_____
Relationship to Patient: _____	Relationship to Patient: _____
Policy Holder's Employer: _____	Policy Holder's Employer: _____

MEDICAL HISTORY

Name of Physician: _____ Physician's Telephone or City/State: _____

Are you in good health? ☐Yes / ☐No

Has there been *any* change in your general health within the past year? ☐Yes / ☐No

-If yes, please specify: _____

Are you currently under the care of a physician? ☐Yes / ☐No

-If yes, please specify: _____

Are you currently taking any prescriptions, over the counter, herbs, supplements or recreational drugs*? ☐Yes / ☐No

-If yes, please list: _____

_____

(*Recreational use combined with local anesthesia may cause a life threatening emergency.)

Do you smoke or use any tobacco in any form? ☐Yes / ☐No

Do you take, or have you taken, Phan-Fen or Redux? ☐Yes / ☐No

Have you ever taken medication for Osteoporosis, like Fosamax (bisphosphonates) or other? ☐Yes / ☐No

Are you allergic to latex or rubber? ☐Yes / ☐No
Have you ever had a reaction to local anesthesia? ☐Yes / ☐No
Do you require antibiotic before dental treatment? ☐Yes / ☐No
Do you have any artificial joints (such as hip or knee replacements)? ☐Yes / ☐No
Have you had any serious trouble associated with any previous dental treatment? ☐Yes / ☐No
-If yes, please specify: _____

WOMEN ONLY

Are you pregnant or is there a possibility of being pregnant? ☐Yes / ☐No
Are you nursing? ☐Yes / ☐No
Are you taking birth control pills? ☐Yes / ☐No

Do you have or have you had any of the following diseases or problems? Please check all that apply. ☐**None**

☐Damaged or artificial heart valves
☐Cardiovascular Disease (heart trouble, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke)
☐Heart Attack
If yes, when?: _____
☐Heart Murmur or Rheumatic Heart Disease
☐High Cholesterol
☐High Blood Pressure (Hypertension)
☐Chest Pain upon exertion
☐Angina
☐Shortness of breath after mild exercise or when lying down
☐Swelling of ankles
☐Inborn heart defects
☐Cardiac Pacemaker
☐Sinus Problems (Sinusitis)
☐Asthma
☐Respiratory problems (Emphysema, Bronchitis, etc)
☐Hay Fever
☐Fainting spells
☐Seizures
☐Diabetes
☐Liver disease or Jaundice
☐Hepatitis
☐AIDS or HIV infection
☐Thyroid problems
☐Arthritis or painful swollen joints
☐Persistent diarrhea / recent weight loss
☐Stomach ulcer or Hyperacidity
☐Kidney Disease
☐Tuberculosis
☐Persistent cough or cough that produces blood
☐Persistent swollen glands in neck
☐Low blood pressure
☐Sexually transmitted disease
☐Epilepsy or other neurological
☐Problems with mental health
☐Problems of the Immune System
If yes, please specify: _____
☐Abnormal bleeding
If yes, please specify: _____
☐Do you have any blood disorder such as Anemia?
If yes, please specify: _____
☐Cancer
If yes, please specify: _____
☐Have you ever had any treatment for tumor or growth?
If yes, please specify: _____

Are you allergic to or have you had a reaction to any medication? ☐**None**

☐ Penicillin	☐ Aspirin	☐ Narcotics
☐ Sulfa drugs	☐ Iodine	☐ Other: _____
☐ Barbiturates, sedatives or sleeping pills	☐ Codeine	

Do you have any disease, condition, or problem not listed above that you think I should know about?

If yes, please specify: _____

DENTAL HISTORY

Purpose of today's visit: _____

Any areas of your mouth hurting you? ☐Yes ☐No

-If Yes, please specify: _____

Do you have a specific concern you want Dr. Park to address first?

_____

Last dental visit: _____ What was done? _____ Last cleaning/x-rays: _____

Name of previous dentist _____ City _____ State _____

How often do you brush? _____ Floss? _____ Do you use a Manual or Electric toothbrush? _____

Please mark all that apply: ☐None

☐Bleeding gums when brushing	☐ Jaw (TMJ) pain	☐ Throbbing toothache
☐ Broken fillings	☐ Loose Teeth	☐ Trauma or injury to the Jaw
☐ Frequent toothaches	☐ Orthodontic treatment (worn braces before)	☐Other _____
☐ Frequent bad breath	☐ Previous treatment for gum diseases	
☐ Frequent sores in the mouth	☐ Swelling of your mouth or jaws	
☐ Grinding or clenching teeth	☐ Sensitive Teeth (cold/hot/sweets)	

Do you feel nervous about having dental treatment? ☐Yes / ☐No

Are you happy with the appearances of your teeth? ☐Yes / ☐No

Would you like your teeth to be whiter? ☐Yes / ☐No

Have you ever had a bad experience in a dental office? ☐Yes / ☐No

-If yes, please explain:

_____

We reserve the right to charge for any appointments not cancelled with 48 hours notice. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all dental & medical questions to ensure the understanding of the time, limitations, potential complications and cost of all treatment. I certify that all the information that I have provided is accurate to the best of my knowledge. I will not hold any member of the dental staff responsible for actions resulting from errors or omissions that I have made in the completion of this form. **Insurance Assignment:** My signature authorizes the release of necessary information needed to process my claim and to pay any benefits to the provider of my service. (Park Dental of Martinsville, Dr. Jong Park)

Signature_____Date_____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES- We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a copy of our office's HIPPA privacy act, our legal duties, and your rights concerning your health information. This notice took effect 9/1/2016 and will remain in effect until we replace it. At that time you will be notified. (You may refuse to sign this acknowledgment.)

Signature_____Date_____/_____/_____

OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other: _____