Cornerstone Dental of Green Brook
314 US HWY 22 WEST
SUITE D
GREEN BROOK, NJ 08812
732-424-8483

REGISTRATION HISTORY
DATE_____

PATIENT'S NAME_____

NAME OF SPOUSE_____

IF A CHILD, PARENT'S NAME_____

STREET ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

CELLPHONE#_____ **HOME#**_____

E-MAIL ADDRESS_____

PATIENT EMPLOYED BY _____**PHONE**_____

BUSINESS ADDRESS_____

PRESENT POSITION_____**HOW LONG** _____

SPOUSE EMPLOYED BY_____**PHONE**_____

BUSINESS ADDRESS_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____**PHONE**_____

WHO WILL PAY THIS ACCOUNT_____

SOCIAL SECURITY NUMBER_____

SPOUSE'S SOCIAL SECURTY NUMBER_____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES
YES_____ **NO**_____

IF SO, NAME OF COMPANY_____**POLICY#**_____
IF INSURANCE COVERED, SOCIAL SECURITY # OF PERSON COVERED_____

DATE OF BIRTH OF THE PERSON COVERED_____

IF YOUR INSURANCE DOES NOT PAY THE BILL, WHO IS RESPONSIBLE FOR PAYING IT_____

WHOM MAY WE THANK FOR REFERRING YOU_____

PURPOSE OF THIS APPOINTMENT_____

PLEASE COMPLETE REVERSE SIDE

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Patient Name: _____DOB_____ **MEDICAL HISTORY**

1. Physician's Name: _____ Phone: ( ) _____
   Have you had any medical care within the past two years? ..... **Yes or No**
   If Yes, describe: _____
2. Are you currently taking any medications, drugs, pill or herbal remedies? ..... **Yes or No**
   If Yes, please list: _____
3. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs?..... **Yes or No**
4. Are you aware of any allergy to any substance or medication: **Yes or No** If Yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... **Yes or No**
6. Indicate which of the following you have had, or have at present. Circle Yes or No to each item

Heart Surgery, Disease, or Attack: **Yes or No**	Kidney Trouble ..... **Yes or No**	Radiation Therapy .....**Yes or No**
Chest Pain ..... **Yes or No**	Ulcers .....**Yes or No**	Chemotherapy ..... **Yes or No**
Congenital Heart Disease..... **Yes or No**	Diabetes ..... **Yes or No**	Tumors /Cancer ..... **Yes or No**
Heart Murmur ..... **Yes or No**	Thyroid Problems ..... **Yes or No**	Hepatitis A, B, or C ..... **Yes or No**
High/Low Blood Pressure ..... **Yes or No**	Glaucoma .....**Yes or No**	Venereal Disease ..... **Yes or No**
Mitral Valve Prolapse ..... **Yes or No**	Contact Lenses ..... **Yes or No**	AIDS/HIV Positive ..... **Yes or No**
Artificial Heart Valve/Pacemaker... **Yes or No**	Emphysema ..... **Yes or No**	Cold Sores/Fever Blisters..... **Yes or No**
Rheumatic Fever ..... **Yes or No**	Tuberculosis ..... **Yes or No**	Hemophilia ..... **Yes or No**
Arthritis/Rheumatism ..... **Yes or No**	Asthma ..... **Yes or No**	Sickle Cell Disease ..... **Yes or No**
Cortisone Medicine .....**Yes or No**	Hay Fever/Allergy/Hives **Yes or No**	Bruise Easily ..... **Yes or No**
Liver Disease/Yellow Jaundice..... **Yes or No**	Latex Sensitivity.....**Yes or No**	Stroke ..... **Yes or No**
Artificial Joints (Hip, Knee, etc.).... **Yes or No**	Sinus Trouble .....**Yes or No**	Neurological Disorders.....**Yes or No**
Epilepsy or Siezures.....**Yes or No**	Fainting or Dizzy Spells ...**Yes or No**	Nervous/Anxious ..... **Yes or No**

7. Do you have or have you had any disease, condition, or problem not listed? .....**Yes or No**
8. Women: Are you pregnant or think you could be pregnant? **Yes ___ Months or No** Nursing? **Yes or No**
9. Do you use birth control prescriptions? ..... **Yes or No**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

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Patient Name: _____ **DENTAL HISTORY**

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays_____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using topical fluoride? (Please circle one) **YES or NO**

What other dental aids do you use (waterpik, toothpick, interplak, etc.)? _____

Do you have any dental problems now? If yes, please describe: _____

Please complete below by circling YES or NO.

Are any of your teeth sensitive to:

Hot or Cold? ..... **YES OR NO**
Sweets? ..... **YES OR NO**
Biting or chewing? ..... **YES OR NO**
Have you noticed mouth odors or bad taste?..... **YES OR NO**
Do you frequently get cold sores, blisters or any other oral lesion? .....**YES OR NO**
Do your gums bleed or hurt? ..... **YES OR NO**
Have you experienced gum disease or tooth loss? ..... **YES OR NO**
Have you noticed any loose teeth or change in your bite? ..... **YES OR NO**
Does food tend to become caught in between your teeth? ..... **YES OR NO**
If yes, where? _____

Do you:

Clench or grind your teeth? ..... **YES OR NO**
Bite your lips or cheeks regularly? ..... **YES OR NO**
Mouth breathe while awake or sleep? ..... **YES OR NO**
Have tired jaws, especially in the AM? ..... **YES OR NO**
Snore or have other sleeping disorders? ..... **YES OR NO**
Smoke/Chew tobacco or use other tobacco products? ..... **YES OR NO**

Have you ever had:

Orthodontic treatment? ..... **YES OR NO**
Oral Surgery? ..... **YES OR NO**
Periodontal Surgery?..... **YES OR NO**
A bite plate or mouth guard? ..... **YES OR NO**
A serious injury to the mouth or head? ..... **YES OR NO**
If yes, please describe: _____

_____

Have you experienced:

Clicking or popping of the jaw? ..... **YES OR NO**
Pain (joint, ear, side of face)? ..... **YES OR NO**
Difficulty in opening or closing the mouth?... **YES OR NO**
Difficulty in chewing on either side of the mouth? .....**YES OR NO**
Headaches, neck or shoulder aches? ..... **YES OR NO**
Are you satisfied with your teeth's appearance? ..... **YES OR NO**
Do you feel nervous about having dental treatment? .....**YES OR NO**
If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience?.....**YES OR NO**
If yes, please describe: _____

Have you ever been told to take a pre-medication prior to dental treatment? **YES OR NO**

Patient Signature _____ Date_____

Dentist Signature _____ Date _____

Authorization to Release Information

I hereby authorize the above named dentist(s) to provide any insurance company claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

_____ _____

Patient or Authorized Guardian's Signature **Date**