IACR Dental, PC
439 60th St.
1st FL
West New York, NJ 07093
Ph # : 201-865-5150

Patient Personal Information

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? __ Yes __ No		Do you have Secondary Dental Insurance? __ Yes __ No	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To

- Y N No Known Allergies
- Y N Aspirin
- Y N Barbiturates / Sleeping Pills
- Y N Codeine
- Y N Erythromycin
- Y N Iodine
- Y N Latex Rubber
- Y N Local Anesthetics
- Y N Metals
- Y N No Epinephrine
- Y N Penicillin
- Y N Prior Hepatitis
- Y N Sulfa Drugs
- Y N Other Narcotics

Check, if applicable

- Y N Arteriosclerosis
- Y N Arthritis
- Y N Asthma
- Y N Autoimmune Disease
- Y N Bladder Trouble
- Y N Blood Clotting Problems
- Y N Blood Transfusion
- Y N Bulimia
- Y N Bronchitis
- Y N Cancer / Tumor or Growth
- Y N Cardiac Pacemaker
- Y N Cardiovascular Disease
- Y N Chemotherapy
- Y N Chest Pain Upon Exertion
- Y N Color Blindness
- Y N Frequent Headaches
- Y N Frequently Dry Mouth / Sjogren
- Y N Gag Reflex
- Y N Gall Bladder Trouble
- Y N Hay Fever
- Y N Heart Attack
- Y N Heart Disease
- Y N Heart Murmur
- Y N Hepatitis
- Y N Herpes
- Y N High Blood Pressure
- Y N Hives
- Y N Jaundice
- Y N Joint Replacement
- Y N Kidney
- Y N Leukemia
- Y N Rheumatic Fever
- Y N Rheumatic Heart Disease
- Y N Rheumatoid Arthritis
- Y N Seizures
- Y N Sexually Transmitted Disease
- Y N Shortness of Breath
- Y N Skin Rash
- Y N Sinus Trouble
- Y N Stomach Ulcers
- Y N Stroke
- Y N Thyroid Problems
- Y N Tuberculosis
- Y N Unusual Weight Loss
- Y N Urinate Frequently

Other

☐ Y ☐ N No Change Since Last Recorded
☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Anorexia
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Pacemaker
☐ Y ☐ N Persistent Diarrhea
☐ Y ☐ N Premedicate
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N See Scanned Documents: Pt Note
☐ Y ☐ N Oral Biphosphanates
☐ Y ☐ N No dental extractions
☐ Y ☐ N IV Biphophonates

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist ____________________

Phone ____________________

Date of your last cleaning ____________________

Last exam date ____________________

Date of your last full series x-rays ____________________

Date of last cavity detection (bitewing) x-rays ____________________

Do your gums bleed while brushing or flossing ? ____________________

Are your teeth sensitive to hot, cold or sweets ? ____________________

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? ____________________

Have you ever had burning of the tongue or cracking of the corners of your mouth ? ____________________

Do you chew/smoke tobacco in any form ? ____________________

Have you had any head, neck or jaw injuries ? ____________________

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? ____________________

Do you clench or grind your teeth ? ____________________

Have you ever had orthodontic treatment ? ____________________

If Yes, date of placement ____________________

Do you wear dentures or partials ? ____________________

If Yes, date of placement of dentures ? ____________________

Are you happy with your dentures ? ____________________

Are you having any specific problems with your teeth, gums, or mouth at this time ? ____________________

Are you happy with your smile ? ____________________

Do you have problems with teeth/fillings breaking ? ____________________

Do you regularly use dental floss ? ____________________

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? ____________________

Do you have difficulty in opening your mouth widely ? ____________________

Do you have an unpleasant taste or odor in your teeth/mouth ? ______

Does food catch between your teeth ? ______

Do you want to learn to control your dental disease and retain your teeth ? ______

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list ______

Medical Questionnaire

Emergency Contact

Emergency contact name ______

Emergency contact phone ______

Emergency contact relationship to patient ______

Medical Questionnaire

Family Physician ______

Phone ______

Are you currently under care of a Physician ? ______

If Yes, what is the condition being treated ? ______

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ______

If Yes, what illness or problem ? ______

Are you currently taking any medication ? ______

If Yes, what ? ______

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ______

Have you ever taken the diet control drug Fen-Phen ? ______

Do you use alcoholic beverages ? ______

Do you smoke ? ______

Women Only

Are you pregnant? ______

If Yes, what is your due date ? ______

Are you currently nursing ? ______

Do you have menstrual period problems ? ______

Are you on hormone replacement therapy ? ______

Are you on birth control pills / fertility drugs ? ______

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list ______

By signing below, I certify that all of the above information is true to the best of my knowledge.

______________________ ______________________

Patient/Guardian Signature **Date**