

Complete Dental Works

765 Queen Anne Road

Teaneck, NJ 07666

Ph # : 201-836-4400

Fax # : 201-801-0768

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	Insurance Name	Phone #	Employer Name	Subscriber Last, First	Subscriber Address	City, State, Zip	Relationship to Patient	Birth Date	Subscriber ID

Patient Medical Information

<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia / Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters / Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Pregnant
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Ankles Swell	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia / Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma / Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease / Angina	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis / Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Hives / Skin Rash	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss
<input type="checkbox"/> Y <input type="checkbox"/> N Prior Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Color Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Urinate Frequently
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Contact Lenses	Allergic To	Other
<input type="checkbox"/> Y <input type="checkbox"/> N Other Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents: Pt Note
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus
<input type="checkbox"/> Y <input type="checkbox"/> N No Change Since Last Recorded	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	
		<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems	

Y N No Known Concerns or Issues

Y N Environmental Allergies

Y N Mitral Valve Prolapse

Y N Autoimmune

Y N AIDS/HIV Infection

Y N Epilepsy

Y N Persistent Diarrhea

Y N Alcohol/Drug Abuse

Y N Fainting Spells / Seizures

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 ever been told you have Pyorrhea ?

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