

**CARING DENTAL ASSOCIATES
1961 MORRIS AVENUE, SUITE B-4
UNION, NJ 07083**

PLEASE PRINT

Patient Information	Dental Insurance
Date _____ Social Security # _____ Patient Name _____ <div style="text-align: center;">Last Name</div> <hr/> <div style="text-align: center;">First Name Middle Initial</div> Address _____ E-Mail _____ City _____ State _____ Zip _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years Patient Employer/School _____ Occupation _____ Employer /School Address _____ Employer/School Phone (_____) _____ Spouse's Name _____ Birthdate _____ SS # _____ Spouse's Employer _____ Whom may we thank for referring you? _____	Who is responsible for this account? _____ Relationship to Patient _____ Insurance Co. _____ Group # _____ Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Subscriber's Name _____ Birthdate _____ SS# _____ Relationship to patient _____ Insurance Co. _____ Group # _____ ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to <div style="text-align: center;"><i>Name of Insurance Company(ies)</i></div> Dr. Joseph P. Prasad dba Caring Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. _____ <div style="text-align: center;">Signature of Patient, Parent, Guardian or Personal Representative</div> _____ <div style="text-align: center;">Please print name of Patient, Parent, Guardian or Personal Representative</div> _____ <div style="display: flex; justify-content: space-between;"> _____ _____ </div> <div style="display: flex; justify-content: space-between;"> Date Relationship to patient </div>

Phone Numbers
Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone(_____) _____ Spouse's Work (_____) _____ Best time and place to reach you _____ IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name _____ Relationship _____ Home Phone (_____) _____ Work Phone (_____) _____

Dental History		
Reason for today's visit _____ Former dentist _____ City/State _____ Date of last dental visit _____ Date of last dental x-rays _____ Place a mark on "yes" or "no" to indicate if you have had any of the following: Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No Chew on one side of the mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No How often do you floss? _____ How often do you brush? _____

Dental Registration and History

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimen, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you ever taken any of the group of drugs collectively referred to as bisphosphonates? These include drugs taken for osteoporosis such as Fosamax, Boniva and Actonel. Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (____) _____

Allergies

- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Iodine
- Latex

- Local Anesthetic
- Penicillin
- Sulfa
- Other _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment?

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____