

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

**PLEASE UPDATE ANY ITEMS THAT HAVE CHANGED SINCE YOUR LAST VISIT**

Patient Information	Dental Insurance
<p>Name _____</p> <p>Today's Date _____</p> <p>Address _____</p> <p>City _____</p> <p>State _____ Zip _____</p> <p>E-Mail _____</p> <p>Home Phone #: _____</p> <p>Cell Phone #: _____</p> <p>Marital Status:</p> <p><input type="checkbox"/> Married    <input type="checkbox"/> Widowed    <input type="checkbox"/> Single    <input type="checkbox"/> Minor</p> <p><input type="checkbox"/> Separated    <input type="checkbox"/> Divorced    <input type="checkbox"/> Partnered for _____ years</p> <p>Patient Employer/School _____</p> <p>Occupation _____</p> <p>Employer /School Address _____</p> <p>Employer/School Phone (_____) _____</p> <p>Spouse's Name _____</p> <p>Birthdate _____</p> <p>SS # _____</p> <p>Spouse's Employer _____</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p>Is patient covered by additional insurance?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Subscriber's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Relationship to patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p><b>ASSIGNMENT AND RELEASE</b></p> <p>I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____</p> <p align="center"><i>Name of Insurance Company(ies)</i></p> <p><small>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.</small></p> <p><small>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.</small></p> <p align="right">_____ Signature of Patient, Parent, Guardian or Personal Representative</p> <p>Date: _____</p>

**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	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<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
Arthritis, Rheumatism	<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
Artificial Heart valves	<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 Joints	<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
Asthma	<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
Allergies	<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
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*Signature* \_\_\_\_\_