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

Name _____
Today's Date_____
Address_____
City_____
State _____**Zip**_____
E-Mail_____
Home Phone #:_____
Cell Phone #: _____
Marital Status:
☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____ years

Patient Employer/School_____
Occupation_____
Employer /School Address_____
_____
Employer/School Phone (_____)_____
Spouse's Name _____
Birthdate _____
SS # _____
Spouse's Employer_____

Dental Insurance

Who is responsible for this account? _____
Relationship to Patient_____
Insurance Co._____
Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ 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
Name of Insurance Company(ies)
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.

_____
Signature of Patient, Parent, Guardian or Personal Representative
Date:_____

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

Signature _____