PATIENT INFORMATION CHART

H. Craig Froonjian, DMD
Family, Cosmetic and Laser Dentistry
One Kinderkamack Road, Oradell, NJ 07649
Tel 201.265.2252 Fax 201.265.1177
www.oradelldentistry.com

We are looking forward to having you join our great dental family of friends and patients. The benefit of a healthy, beautiful smile is immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You

Last Name:	**First Name:**	**Middle Initial:**
The name you prefer to be called:		Date of Birth: ___/___/___
If child, parent or guardian's name:		
Marital Status: ___Single ___Married ___Divorced ___Widowed ___ Under age 18		Social Security #:_____ Driver's License #: _____
Address, City, State, Zip:		
Home #:		Cell #:
Work #: Ok to call? Y / N		E-Mail Address:
When is the best time to call?	Where?	Phone #:
In case of emergency, who should be contacted?		Phone #:
Who can we thank for referring you to our office?		Special interests or hobbies?

Insurance Information

Primary Coverage	**Secondary Coverage**
Subscriber:	Subscriber:
Relationship to patient:	Relationship to patient:
Insured's birthdate:	Insured's birthdate:
Soc. Sec. # or ID #:	Soc. Sec. # or ID #:
Employer:	Employer:
Occupation:	Occupation:
Insurance Carrier:	Insurance Carrier:
Group #:	Group #:
Address:	Address:
City/State/Zip:	City/State/Zip:

Medical History

Current Health Status: ___ Excellent ___Good ___Fair ___Poor
Current Prescription Medications:

_____

_____

Women:
Are you pregnant? Y / N If yes, how far along? _____
Planning pregnancy in the future? Y / N When? _____
Are you current taking birth control pills? Y / N

Have you ever had or been treated for the following medical problems?
Please check each positive response and explain below:

___ Heart Attack, Stroke & Heart problems
___ Heart Murmur or Rheumatic Fever
___ High or Low Blood Pressure
___ Artificial Prosthesis (heart valve or joints)
___Abnormal Bleeding
___Anemia
___Asthma
___Kidney Disease
___Liver Disease
___Hepatitis (Type ____)
___Diabetes
___Digestive Disorder (acid reflux)
___Osteoporosis: taking Bisphosphonates? Y / N
___ Epilepsy, Seizures or Fainting
___ Viral Infections & Cold Sores
___ Lumps or swelling of the mouth
___Tumor, abnormal growth
___Cancer, Chemotherapy, Radiation
___Venereal Disease
___AIDS or HIV
___Emotional problems
___Psychiatric problems
___Anti-depressant medication
___Drugs, Alcohol dependency

_____

Have you ever been treated for any other illness not listed above? Y / N If yes, explain below:

_____

_____

Do you need to be pre-medicated before dental treatment? Y / N. If yes, what medication?

_____

Are you allergic to any medication? Y / N If yes, mark which ones below.

__Penicillin
__Erythromycin
__Aspirin
__Codeine
__Local Dental Anesthetic
__Metals (gold, nickel)
__Latex
__Other, please specify

_____

Do you snore at night? Y / N
Do you have difficulty sleeping at night? Y / N
Have you ever been diagnosed with sleep apnea? Y / N

Name of Pharmacy: _____ Telephone #: _____

Smile Evaluation

Reason for today's visit: _____
Are you currently in pain or discomfort with your teeth or gums? Y / N
Please explain _____

How would you describe the condition of your teeth and gums? ___Excellent ___Good ___ Fair ___Poor
Name of previous dentist: _____ Phone #:_____
Date of last visit:_____
I routinely see my dentist every: ___3 mos. ___4 mos. ___6 mos. ___12 mos. ___Not routinely
Are you fearful of dental treatment? Y / N Scale of 1 to 10 (very) _____
Have you had an unfavorable dental experience? Y / N _____
_____
Have you ever had complications from a past dental treatment? Y / N _____
_____

Have you ever had trouble getting numb or have had reactions to local anesthetic? Y / N
Did you ever had braces, orthodontic treatment or had your bite adjusted? Y / N
How often do you brush _____, and floss _____ your teeth?
Do your gums bleed when you brush? Y / N Floss? Y / N
Have you ever had pain in your jaw joints? Y / N
Do you get headaches? Y / N
Do you grind your teeth? Y / N
Have you ever been treated for TMJ? Y / N If yes, please explain. _____
_____

Do you snore at night? Y / N If there was an easy way to stop, would you like to know more about it? Y / N
Do you like the way your teeth look? Y / N
Please explain_____
Are you happy with the color of your teeth? Y / N
Would you like your teeth to be straighter? Y / N
Do you have spaces between your teeth that you would like to close? Y / N
Do you like the shape of your teeth? Y / N
Do you have missing teeth that you like replaced? Y / N
Do you have old silver fillings that you would like replaced with tooth-colored fillings? Y / N

If you could wave a magic wand, and change anything you could about the health or appearance of your smile, what would you do?_____
_____
_____

I understand that the information provided by me is correct to the best of my knowledge and all information will be held in the strictest confidence, and only will be used to improve communications between Dr. Froonjian and myself. I also consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of same by the doctor and his staff in scientific papers, demonstration, website or educational purposes.

Signature: Date: