DENTAL ASSOCIATES OF BASKING RIDGE

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Individual Practices of:
Steven M. Kuitems, D.M.D. • Sam S. Faltas, D.D.S. • William J. Ratz, D.M.D.

Patient's Name: _____ SS#:_____
Last First Middle

I prefer to be called: _____ Date of Birth: _____ ☐ Male ☐ Female

Home Address: _____
Street City State Zip Code

Phone Numbers: _____
Home Work Cell Phone E-mail Address

Marital Status: S M D W Name of Spouse: _____

Your Employer: _____ Name/Address/Phone

Occupation: _____ Whom may we thank for referring you? _____

Responsible party for this account:_____ SS#: _____ Work #: _____

Previous Dentist: _____ Reason for Leaving: _____

Other family members seen by us: _____

Primary Dental Insurance:_____
Insurance Company Address Phone #

Insured's: _____
Name Date of Birth SS# Employer Group #

Secondary Dental Insurance:_____
Insurance Company Address Phone #

Insured's: _____
Name Date of Birth SS# Employer Group #

Signature on File

I authorize use of this form as a release of my information in all my insurance submissions. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I understand that I am responsible for my bill and all bills over 60 days will be charged a finance fee of 1½% per month. Should I fail to pay my bill, and referral to a collection agency becomes necessary, I understand that I will be responsible for payment of all collection and/or attorney's fees.

Signature: _____ Date: _____

MEDICAL HISTORY

FOR

_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications (prescribed or over the counter) or supplements? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____

Are you on a special diet? Yes No If yes, please explain: _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: If yes, please explain: _____

_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in the Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you in pain? _____ Have you ever had problems associated with dental treatments? _____

Have you ever experienced discomfort with your jaw joint (TMJ)? _____

Are your toothbrush bristles: Hard Medium Soft?

How many times do you floss each week? _____ How many times do you brush each day? _____

Is there anything that concerns you about the appearance of your teeth? _____

I understand that the information that I have given today is correct to the best of my knowledge. **I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.** I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.
I understand that payment is due in full at the time of treatment unless prior arrangements have been approved.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Comments_____

_____