### Medical History Notes, Current Medications, Consults (office use only)

Date	
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# Steven Denholtz, D.M.D.

268 Route 206, Bartley Square • Flanders, NJ 07836 973-252-1600

#### WELCOME!

We are interested in the best dental health care for you. In order to do this, we must know some things about you. Please fill in this form carefully. Of course, all information will be held strictly confidential.

PATIENT INFORMATION First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Street:\_\_\_\_\_ City, State, Zip\_\_\_\_\_ Date of Birth: / / Sex:\_\_\_\_\_ Marital Status\_\_\_\_\_

# FINANCIAL RESPONSIBILITY

Phone Home \_\_\_\_\_ Fmail Work——— (Parent's for a child) Cell#———— Person responsible for Payment:\_\_\_\_\_ Street: \_\_\_\_\_ City, State, Zip: EMPLOYER: Address: Occupation: \_\_\_\_ DENTAL INSURANCE One Two policies are in effect. Insurance Company: Address:\_\_\_\_\_ Name of Employee: \_\_\_\_\_\_\_Birthdate:\_\_\_\_\_\_ Employee's Social Security Number: Employee's Local #: \_\_\_\_\_ Group #:\_\_\_\_ Employee's Group Name: Patient's Relation to Employee: Self Spouse Child Other I agree I am responsible for all costs of services rendered, regardless of insurance. I authorize the release of information to appropriate parties and assign insurance benefits to Steven Denholtz DMD. I authorize and consent to Dr. Denholtz

and his staff performing such procedures that in Dr. Denholtz professional judgment are necessary. I agree that balances over 60 days are subject to 19.8%apr interest and I authorize charging my credit and/or debit card on any portion of such late balance and agree to pay attorneys' fee of 33.3% and collection cost on late balances. I have had the opportunity to read the HIPPA "notice of privacy" and agree to its terms. Signature

#### OPTIONAL BUT HELPFUL...

How did you hear about our office?\_\_\_\_\_ Any comments you feel would help us serve you better?\_\_\_\_\_

#### MEDICAL HISTORY

Patient's Physician:	
Dr.'s City/Phone:	
How is your general health?  Do you or have you ever had?  YES NO	
1) Rheumatic Fever [ ] [ ] 10 2) Heart murmur [ ] [ ] 11 3) Hepatitis [ ] [ ] 12 4) Diabetes [ ] [ ] 13 5) Heart condition [ ] [ ] 14 6) Frequent Headaches [ ] [ ] 15 7) Digestive problems [ ] [ ] 16 8) Asthma	D) Bleeding problem [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [
17) Any medical condition?	
18) Blood pressure is (Low) (Normal 19) Allergic to? (Penicillin) (Codeine)	
20) Recent operations or hospitalizations?_	
21) What medications, vitamins or homeopa	thic substances, if <u>any</u> are you taking?
22) How much do you use:	· · ·
Coffee/Tea	Cigarettes, pipe or cigars
23) Are you pregnant? (No) (Yes) - > Ho	Alcoholic beverages Due date
24) Are you taking oral contracentives "the n	

# **DENTAL HISTORY**

25) Reaso	on for this visit?
26) Last d	lental exam?
27) Do yo	u avoid any part of your mouth due to sensitivity?
28) Do an	y teeth hurt? (now) (cold) (hot) (sweets)
	(chewing) (change of position) (brushing)
Do you or	have you ever had?
-	YES NO YES NO
29) Gum (	
30) Bieedi	ing or tender gums [ ] [ ] 33) Facial pain or earache [ ] [ ] s condition [ ] [ ] 34) Clenching or grinding teeth [ ] [ ]
35) A rem	ovable denture (bridge)? How old?
36) Do yo	u like your smile (how it looks)?
3.7	
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Please hand this to the receptionist when you have finished both sides. Thank you.