PATIENT UPDATE FORM

Long Valley, NJ
1 Shadetree Place • (908) 852-8544

Hackettstown, NJ
51 Main Street • (908) 852-5760

About You

Today's Date: ___________ *Email:* ___________________________

Name: ____
LAST FIRST M.I.

I prefer to be called: ______________________________________

Birthdate: ___ / ___ / ___ *Age:* ______ *SS#:* ______________

Home Address: ____

____
CITY STATE ZIP CODE

Status: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Home Phone: ______________________ *Cell:* _______________

Work #: _____________________

Medical History

Do you have a personal Physician? YES NO

Physicians Name: ____

Phone #: ____________________ *Last Visit Date:* ___________

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? YES NO

If yes, please explain: _____________________________________

____

____

Are you taking any prescriptions / OTC drugs? YES NO

If yes, please list: ____

____

Are you allergic to any of the following?

Aspirin	Y	N	Latex	Y	N
Any metals or plastics	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Other	Y	N
Erythromycin	Y	N			

Please list any other drugs / materials you are allergic to:

____

____

For Women:

Are you taking Birth control?	Y	N
Are you Pregnant?	Y	N
If yes, week # _________		
Are you nursing?	Y	N

Dental Insurance (Primary / Secondary)

CIRCLE ONE

Name: ____

Billing Address: ____________________________________

____
CITY STATE ZIP CODE

Phone: ____

Group #: ____

Insured's Name: _____________________________________

Relation: ____________________ *Birthdate:* ___ / ___ / _____

Insured's SSN#: ____________________________________

Insured's Employer: _________________________________

Employer Address: __________________________________

____

Employer's Phone #: _________________________________

Have you ever had any of the following diseases or medical problems?

Anemia	Y	N	Heart Surgery	Y	N
Arthritis	Y	N	Abnormal Bleeding	Y	N
Artificial Bones / Joints	Y	N	Hepatitis Type? _____	Y	N
Artificial Valves	Y	N	High / Low Blood Pressure	Y	N
Asthma	Y	N	HIV+ / AIDS	Y	N
Blood Transfusion	Y	N	Hospitalized (any reason)	Y	N
Cancer / Chemotherapy	Y	N	Kidney Problems	Y	N
Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N
Diabetes	Y	N	PsychiatricTreatment	Y	N
Difficulty Breathing	Y	N	Radiation Therapy	Y	N
Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever	Y	N
Emphysema	Y	N	Shingles	Y	N
Glaucoma	Y	N	Sinus Problems	Y	N
Fainting Spells	Y	N	Tuberculosis (TB)	Y	N
Heart Attack / Stroke	Y	N	Ulcer / Colitis	Y	N
Heart Murmur	Y	N	Venereal Disease (STD)	Y	N

Please list any serious medical condition(s) that you have ever had: ____

____

Emergency Contact

His / Her Name: _____________________________________

Relation: ____

Home Phone: _______________________________________

Work Phone: _______________________________________

DENTAL SMILE ANAYSIS

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Your smile affects your self-image, and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile. Go to a mirror, smile as wide as you can, and ask yourself the following questions:

Are any of your teeth yellow, stained or somewhat discolored?	*YES*	*NO*
Would you like your teeth to be whiter?	*YES*	*NO*
Do you have any gaps or spaces between your teeth?	*YES*	*NO*
Are any of your teeth turned, crooked, or uneven?	*YES*	*NO*
Are you missing any teeth?	*YES*	*NO*
Do you see any pitting or defects on the surfaces of your teeth?	*YES*	*NO*
Are the edges of any teeth worn down, chipped or uneven?	*YES*	*NO*
Do any of your teeth appear too small, short, large or long?	*YES*	*NO*
Do you have any prior dental work that appears unnatural?	*YES*	*NO*
Do you have any crowns or bridges that appear dark at the edge of your gums?	*YES*	*NO*
Do you have any gray, black or silver (mercury) fillings in your teeth?	*YES*	*NO*
Do you have a "gummy" smile (too much of your gums show when smiling)?	*YES*	*NO*
Are your gums red, sore, puffy, bleeding or receded?	*YES*	*NO*
Does the appearance of your smile inhibit you from laughing or smiling?	*YES*	*NO*
When being photographed, do you smile with your lips closed	*YES*	*NO*
instead of flashing a full smile?	*YES*	*NO*
Are you self-conscious about your teeth or smile?	*YES*	*NO*
Would you like to change anything about the appearance of your teeth or smile?	*YES*	*NO*

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Liebes to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Liebes.

I authorize my insurance company to pay Dr. Liebes, D.D.S. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Liebes, D.D.S. to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charged whether or not paid by insurance.

Signature: ______________________________ *Date:* ____________