LIEBES DENTAL

PATIENT HISTORY 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 #: _____

Employer: _____

Years Employed: _____ Occupation: _____

When are the best times to reach you: _____

Other family members seen by us: _____

Whom may we thank for referring you? _____

Previous Dentist? _____

Last Visit Date? _____

Spouse Information

His / Her Name: _____

Employer: _____

Work Ph: _____ SS#: _____

Birthdate: ___ / ___ / ___

Person Responsible for Account
(if different from above)

Name: _____

Work #: _____ Home#: _____

Billing Address: _____

_____
CITY STATE ZIP CODE

Relation: _____ SS#: _____

Employer: _____

Employer Address: _____

_____
CITY STATE ZIP CODE

Dental Insurance (Primary)

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 #: _____

Dental Insurance (Secondary)

Name: _____

Billing Address: _____

_____
CITY STATE ZIP CODE

Phone: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: ___ / ___ / _____

Insured's SSN#: _____

Insured's Employer: _____

Employer Address: _____

_____
CITY STATE ZIP CODE

Employer's Phone #: _____

Emergency Contact

His / Her Name: _____

Relation: _____

Home Phone: _____

Work Phone: _____

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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: _____

_____

_____

_____

Have you ever had any of the following?

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	Psychiatric Treatment	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: _____

_____

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 History

Are you in discomfort today? _____

Are there any main concerns you would like the dentist to address today? _____

Do you currently have:

Bad Breath	Y	N	Sometimes
Sensitivity to sweets	Y	N	Sometimes
Sensitivity to cold	Y	N	Sometimes
Loose or broken teeth	Y	N	Sometimes
Bleeding gums	Y	N	Sometimes
Sensitivity when biting	Y	N	Sometimes
Grinding or clenching	Y	N	Sometimes
Clicking or popping jaw	Y	N	Sometimes
Sores or growths in mouth	Y	N	Sometimes

How often do you brush? _____

How often do you floss? _____

How do you feel about the appearance of your teeth?

_____

Have you experienced an adverse reaction during or in conjunction with a medical or dental procedure?

_____

_____

_____

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:* _____