JOSEPH LOBODA, DMD (973) 492-8100

PATIENT FORMS

Date: _____

Name: _____ Birthdate_____ Sex_____
Address: _____
Social Security#: _____ Phone#: _____ Work#: _____
Cell#: _____ Email Address: _____
Marital Status: Single _____ Married _____ Divorced _____ Separated _____
Employer: _____ Address: _____
Spouse/Parent (if minor): _____
Are you covered by dental insurance? _____
Insurance Co.: _____ Policy # _____ ID# (Social) _____
Insured's Name: _____ Birth Date: _____
Employer Name, Address, Phone#: _____
Student Status: F/T ____ P/T ____ Name of University _____
Whom may we thank for referring you to the office? _____

HEALTH HISTORY: Please answer the following as accurately as possible.

Are you in good health? _____ Last physical exam? _____
Have there been any changes in your general health in the last year? _____
If yes, please explain: _____
Have you had any serious illnesses or operations? _____
Name of physician: _____ Phone#: _____

PLEASE CHECK YES OR NO TO THE FOLLOWING CONDITIONS:

Rheumatic fever or heart disease	**Yes ___**	**No ___**
Congenital heart disease	**Yes ___**	**No ___**
Have you suffered from any cardiovascular diseases (heart attack, stroke, coronary insufficiency, arteriosclerosis, emphysema)?	**Yes ___**	**No ___**
High blood pressure	**Yes ___**	**No ___**
Low blood pressure	**Yes ___**	**No ___**
Do you ever get chest pains on slight exertion?	**Yes ___**	**No ___**
Do you get short of breath after exercise?	**Yes ___**	**No ___**
Cardiac surgery, coronary bypass, valve prosthesis angioplasty?	**Yes ___**	**No ___**
Do you have Mitral Valve Prolapse?	**Yes ___**	**No ___**
Have you ever had fainting spells or seizures?	**Yes ___**	**No ___**
Are you allergic to any foods or medications?	**Yes ___**	**No ___**
If yes, what are you allergic to? _____		
Do you have asthma or hay fever?	**Yes ___**	**No ___**
Do you have diabetes?	**Yes ___**	**No ___**

PLEASE COMPLETE THE OTHER SIDE.

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Have you ever been diagnosed with any of the following?

Hepatitis	**yes ___ no ____**	**Mononucleosis**	**yes ___ no ___**
Ulcers	**yes ___ no ____**	**Kidney problem**	**yes ___ no ___**
Chronic bronchitis	**yes ___ no ____**	**Tuberculosis**	**yes ___ no ___**
Hemophilia	**yes ___ no ____**	**Arthritis**	**yes ___ no ___**
Venereal disease	**yes ___ no ____**	**AIDS**	**yes ___ no ___**

Have you ever:

Required a blood transfusion? yes ___ no ____
Been an IV drug user? yes ___ no ____
Been diagnosed as HIV positive? yes ___ no ____
Had radiation or chemotherapy? yes ___ no ____

Are you taking any of the following medications?

Antibiotics yes ___ no ____
Anticoagulants (blood thinners) yes ___ no ____
High blood pressure medication yes ___ no ____
Cortisone yes ___ no ____
Tranquilizers yes ___ no ____
Insulin, orinase or other similar medication yes ___ no ____
Digitalis or other heart medication yes ___ no ____
Dilantin yes ___ no ____
Any other medication? _____
Are you pregnant? yes ___ no ____

DENTAL HISTORY

When was your last exam? _____ X-rays? _____ Cleaning? _____
Have you ever had periodontal treatment? _____ If yes, when? _____
Have toy ever had orthodontic treatment? _____ If yes, when? _____
Do you get frequent headaches? _____ Ringing in ears? _____
Clicking or popping sound on opening of jaw? _____
Have you ever had abnormal bleeding associated with dental treatment? _____
Are you experiencing pain at this time? Yes ____ No ____ Type of pain? _____
Heat _____ Cold _____ Sweets _____ When biting down _____
Are your gums inflamed? _____ Bleeding? _____ Swollen? _____
Are you happy with your smile? Yes _____ No _____
If not, how would you like to improve it? _____
Do you wear partial dentures? _____ Full dentures? _____ Fixed bridges? _____
Is there anything else we should know about your medical/dental health in order to better serve you? _____
Do we have your consent to use "Signature on file" for your dental claims, which we will be filing on your behalf? YES _____ NO _____

PATIENT SIGNATURE _____
(or parent if minor)