Joseph A. Loboda, III, DMD

1395 Route 23, Butler, NJ 07405
973-492-8100

Date: ____________________
Name: _____________________________Birthdate ____________Gender_______
Address: ____
Social Security#: ____________Phone#: _______________Work#: __________
Cell#: ______________E-mail address: _________________________________
Marital Status: Single_____Married______Divorced_______Widowed_______
EmergencyContact:____
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#: _______________________________________
Whom may we thank for referring you to the office? _______________________

DENTAL HISTORY
When was your last dental exam? _________X-rays?________Cleaning?________
Have you ever had periodontal treatment? _________If yes, when? _____________
Have you 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 inflammed? _____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 or 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____

Please note that any services not covered by your insurance for any reason are your responsibility.

SIGNATURE____
(Or parent if minor)

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Please list any medical conditions:____

Please list all medications:____

Please list any allergies:____

Please list past surgical history:____

Did you chemotherapy or radiation therapy (and when):______________________

Do you have a congenital heart issue or artificial valve: Yes___ No___

Do you take Bisphosphonates (Fosamax, Prolia, etc.)? Yes___ No___

Do you smoke? Yes___ No___

HEALTH HISTORY: Please answer the following as accurately as possible.
Last physical exam?_______________
Name of physician: ____________________________Phone #_________________

PLEASE CHECK YES OR NO TO THE FOLLOWING CONDITIONS:

Cardiovascular Disease (heart attack, stroke, arteriosclerosis, emphysema)	**Yes____**	**No____**
High blood pressure	**Yes____**	**No____**
Have you ever had cardiac surgery, coronary bypass, valve prosthesis or angioplasty?	**Yes____**	**No____**
Have you ever had fainting spells or seizures?	**Yes____**	**No____**
Do you have asthma or hay fever?	**Yes_____**	**No____**
Do you have diabetes?	**Yes_____**	**No____**

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_____**
Herpes	**yes_____no_____**	**AIDS**	**yes_____no_____**

Are you taking any of the following medications?

Antibiotics	**yes_____no_____**
Anticoagulants (blood thinners)	**yes_____no_____**
High blood pressure medication	**yes_____no_____**
Tranquilizers	**yes_____no_____**
Insulin or other similar medication	**yes_____no_____**
Digitalis or other heart medication	**yes_____no_____**
Dilantin	**yes_____no_____**