327 Bridge Plaza North
Fort Lee, NJ, 07024
(201) 592-6222
www.SingerDentist.com

Welcome! The benefits of a healthy, beautiful smile are immeasurable. Our goal is to allow you to obtain the healthy teethand attractive smile you want and deserve.

General Information

Name: | Home Phone:
I like to be called: | Cell Phone:
Address: Apt #: | Best # to reach you:
City/State/Zip: | Email:
Social Security #: | Patient's School/College:
Birthday: | School City/State:
Patient/Parent's Employer: | Spouse/Parent:
Employer Address: | Employer:
Employer City/State/Zip: | Work Phone: Ext:
Employer Phone: Ext: | Emergency Contact:
Who referred you: | Emergency Phone #:

Current Needs

What is your goal for today? Date of last dental visit

Do you have concerns about today's visit?

Are you seeking a second opinion? Yes No? Regarding what treatment?

Responsible Party

Name: | Birthdate:
Address: | Home Phone:
Employer: | Work Phone:
Relationship to Patient:

Payment Information

The options for payment will be explained to you after treatment plans have been discussed. Payments may be made in cash, check, VISA, MasterCard, American Express, Discover, or we can arrange third party financing for you.

Do you have dental insurance? Yes No | If you have dental insurance, please provide us with the appropriate information so we can submit claims electronically for prompt reimbursement. As a courtesy to you, we will fill out the necessary forms for your insurance so you are reimbursed directly. We will make every effort to help you maximize your benefits.

Appointments are scheduled to allow sufficient time to attend exclusively to your needs. For appointments which are not kept or cancellations with less than 48 hours notice, we reserve the right to charge cancellation fee.

Permission to Use Photography and Slides

I hereby give Dr. Joel Singer authorization to use my photographs/slides for educational or promotional purposes.

Signature ______________________________ Date ______________

Medical History

Physicians name　　　　　　　　　　Date of last physical exam

Has there been any change in your general health in the past year?

Are you currently under the care of a physician?　Yes　No　　If yes, for what reason?

Please list any prescription medications you are currently taking:

Do you smoke or use tobacco products?　Yes　No　　If Yes, how much per day use?

Women, are you:　Pregnant?　If so, how many months?　　Taking birth control pills?　　Nursing?

Do you have, or have had, any of the following: (Please check all applicable)

Anemia	Herpes	Cosmetic Surgery	Psychiatric Care	Diabetes
Hay Fever	Tuberculosis	Asthma	Allergies (to other meds)	Excessive Bleeding
Tested HIV +	Arthritis/Bursitis	Mumps	Circulatory Problems	Stroke
Appetite Changed	Malignancies	Anesthetic Allergies	Radiation Treatment	Sinus Problems
Hepatitis	Typhoid Fever	High/Low Blood Pressure	Latex Sensitivity	Faint Easily
Thirsty Often	Measles	Nervous Problems	Rheumatic Fever	Skin Disease
Any Heart Problems	Venereal Disease	Penicillin Allergy	Scarlet Fever	Epilepsy

Have you been hospitalized in the last 5 years:　Yes　No　If Yes, when? Why? (Provide details below.)

Have you ever been premedicated before dental treatment?　Yes　No

Other information we should know about your general health:

Dental Health & Appearance

Are you having discomfort at this time?	Yes	No	
Have you been to a dentist in the last 6 months?	Yes	No	
Have you lost any teeth other than wisdom teeth?	Yes	No	
Have you ever had missing teeth replaced?	Yes	No	N/A
Have you had any complications with a tooth removal?	Yes	No	N/A
If you have had teeth replaced, are you happy with the results?	Yes	No	N/A
Are your teeth sensitive to heat, cold, sweet, sour, or when chewing	Yes	No	
Have you ever had your teeth straightened or had orthodontics (braces) in the past?	Yes	No	
Do your gums bleed?	Yes	No	
Have you ever had treatment for gum problems?	Yes	No	
Do you ever feel (or have been told) that you don't have fresh breath?	Yes	No	
Do you clench your teeth during the day or suspect you do during sleep?	Yes	No	
Do you have any pain in, or around, your ears?	Yes	No	
Are you aware of any swelling or lumps in your mouth?	Yes	No	
Do you ever experience a burning sensation in your mouth?	Yes	No	
Have you ever had professional instructions on home dental care?	Yes	No	
Are you familiar with sedation and relaxation methods that can be combined with dental treatment?	Yes	No	
Are your teeth as white as you would like?	Yes	No	
Have you ever considered (or discussed) improving the appearance of your smile?	Yes	No	

How do you feel about dental visits?　Relaxed　Anxious　Neutral

How often do you brush your teeth?　　How often do you floss your teeth?

Please list the obstacles that have prevented you from achieving your oral health and appearance goals in the past:

Authorization

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify Dr. Singer of any change in my health or medication.

Patient/Guardian Signature ______________________________ Date ____________