Welcome

Barrington Dental Associates, LLC
110 Trenton Ave, Suite 1
Barrington, NJ 08007
Phone: 856-547-0100 Fax: 856-547-3105
Email: smiles@barringtondental.net www.barringtondentalassociates.com

Patient Information

First Name: _____ Last Name: _____ MI: ___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Preferred Method of Contact: _____

Birth Date: _____ Age: ____ Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Are you a student? ○ Yes ○ No Name of School: _____

Emergency Contact Name: _____ Phone Number: _____

Whom may we thank for referring you? _____

Has any member of your family been treated in our office? ○ Yes ○ No Who? _____

Account/Responsible Party

Person Responsible for account: _____ Relationship to patient: _____

Name: _____ Spouse/Partner: _____

Social Security #: _____ Social Security #: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Insurance Information

Primary Insurance Holder: _____ **Secondary Insurance Holder:** _____

Holder Address: _____ Holder Address: _____

Holder Phone #: _____ Holder Phone #: _____

Carrier's Name: _____ Carrier's Name: _____

Group #: _____ Group #: _____

Social Security #: _____ Social Security #: _____

Birth Date: _____ Birth Date: _____

Employer: _____ Employer: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication you may be taking could have an important interrelationship with the dentistry you will receive.

Allergies

Are you allergic to any of the following?

◯Aspirin ◯ Penicillin ◯ Codeine ◯Acrylic ◯Metal ◯ Latex ◯ Local Anesthetics

◯Other Explain: _____

Dental

Do you have a specific dental problem? Describe: _____ ◯ Yes ◯No

Do you have dental examinations on a routine basis? Last visit: _____ ◯ Yes ◯No

Do you think you have active decay or gum disease? _____ ◯ Yes ◯No

Do you brush and floss routinely? _____ ◯ Yes ◯No

Do your gums ever bleed? Explain _____ ◯ Yes ◯No

Do you like your smile? Why _____ ◯ Yes ◯No

Does food catch between your teeth? Any loose teeth? _____ ◯ Yes ◯No

Do you want to keep your remaining teeth? _____ ◯ Yes ◯No

Do you ever having clicking, popping or discomfort in your jaw? Do you brux or grind? _____ ◯ Yes ◯No

Have your past experiences in a dental office been positive? _____ ◯ Yes ◯No

Do you smoke or chew? Any sores or growths in your mouth? _____ ◯ Yes ◯No

Name of previous dentist? _____ ◯ Yes ◯No

Date of last full mouth x-rays _____ ◯ Yes ◯No

Medical

Are you under a physician's care now? Explain: _____ ◯ Yes ◯No

Have you been hospitalized or had a major operation? Explain: _____ ◯ Yes ◯No

Have you ever had a serious head or neck injury Explain _____ ◯ Yes ◯No

Are you taking any medications, pills or drugs? Explain _____ ◯ Yes ◯No

Are you on a special diet? Explain _____ ◯ Yes ◯No

Do you use controlled substances? _____ ◯ Yes ◯No

Women

Are you pregnant/trying to get pregnant? _____ ◯Yes ◯ No

Taking oral contraceptives? _____ ◯Yes ◯ No

Are you nursing? _____ ◯Yes ◯ No

Do you have or have you had any of the following? (Circle answer)

AIDS/HIV	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Rheumatic Fever	Yes	No
Alzheimer's	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatism	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B/C	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Easily Winced	Yes	No	Herpes	Yes	No	Shingles	Yes	No
Angina	Yes	No	Emphysema	Yes	No	Blood Pressure	Yes	No	Sickle Cell Disease	Yes	No
Arthritis/Gout	Yes	No	Epilepsy/Seizures	Yes	No	Hives/Rash	Yes	No	Sinus Trouble	Yes	No
Artific Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Spina Bifida	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Stomach Disease	Yes	No
Asthma	Yes	No	Fainting/Dizzy	Yes	No	Kidney Issues	Yes	No	Intestine Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling limbs	Yes	No
Breathing Problem	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No	Jaw Pain	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Heart Attack	Yes	No	Parathyroid Disease	Yes	No	Tumors/Growths	Yes	No
Chest Pains	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No
Cold Sores	Yes	No	Heart Pace Maker	Yes	No	Radiation	Yes	No	Venereal Disease	Yes	No
Cong Heart Disorder	Yes	No	Hear Disease	Yes	No	Recent Weight Loss	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Frequent Headache	Yes	No	Renal Dialysis	Yes	No			

Have you had any other series illness not listed above? _____

Method Of Payment

Responsible party currently has an account with our office

◯Yes ◯No Driver's License State: _____ Driver's License #: _____

Please Note: Service Charges may apply to unpaid/late accounts. Return checks subject to $25 fee

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____ Date: _____

Patient Signature

Acknowledgement

To the best of my knowledge, these questions have been accurately answered. I understand that proving incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ Date: _____

Patient Signature