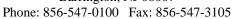
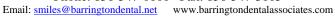


Barrington Dental Associates, LLC

110 Trenton Ave, Suite 1 Barrington, NJ 08007







Patient Information

First Name:										
	ty:Zip:									
Home Phone: Work Phone:	Cell Phone:									
Email:	Preferred Method of Contact:									
Birth Date: Age: Mar	ital Status: O Married O Single O Divorced O Widowed									
Are you a student? O Yes O 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? O Yes O 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?	
OAspirin OPenicillin OCodeine OAcrylic OMetal OLatex	O Local Anesthetics
Other Explain:	
Dental	
Do you have a specific dental problem? Describe:	
Do you have dental examinations on a routine basis? Last visit:	O Yes ONo
Do you think you have active decay or gum disease?	O Yes ONo
Do you brush and floss routinely?	
Do your gums ever bleed? Explain	O Yes ONo
Do you like your smile? Why	O Yes ONo
Does food catch between your teeth? Any loose teeth?	O Yes ONo
Do you want to keep your remaining teeth?	O Yes ONo
Do you ever having clicking, popping or discomfort in your jaw? Do you brux or grind?	O Yes ONo
Have your past experiences in a dental office been positive?	O Yes ONo
Do you smoke or chew? Any sores or growths in your mouth?	O Yes ONo
Name of previous dentist?	O Yes ONo
Date of last full mouth x-rays	\bigcirc Yes \bigcirc No
Medical	
Are you under a physician's care now? Explain:	
Have you been hospitalized or had a major operation? Explain:	O Yes ONo
Have you ever had a serious head or neck injury Explain	
Are you taking any medications, pills or drugs? Explain	
Are you on a special diet? Explain	
Do you use controlled substances?	O Yes ONo
Women	
Are you pregnant/trying to get pregnant?	OYes ONo
Taking oral contraceptives?	OYes ONo
Are you nursing?	OYes ONo

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 Heart Disease Yes No Recent Weight Loss Yes No Yellow Jaundice Yes No Convulsions Yes No Frequent Headache Yes No Renal Dialysis Yes No Heave 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 dential tro 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	D '	,		641 611 1 2	1 (6:							
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