

Nick Romanides D.M.D

7608 Bergenline Avenue
North Bergen, NJ 07047
(201) 869-1107

Date: _____

Patient Information

Patient Name: _____
Last, First MI (Preferred Name)

Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____ Age: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Email: _____ Cell Phone: _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

• Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Dental History

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing.....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth feel painful.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth.....?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had periodontal treatment (gums).....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had orthodontic treatment before?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced any of the following problems:			Have you ever received oral hygiene instructions.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking in your jaw.....	<input type="checkbox"/>	<input type="checkbox"/>	Regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening or closing Your jaw?	<input type="checkbox"/>	<input type="checkbox"/>			

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend

Dental Office School Work Other _____

Name of person or office referring you to our practice: _____

Signature of patient, parent or guardian Date: _____

Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street
Apartment # _____
City State Zip Code

Emergency Contact Information

Name: _____ Relationship to the Patient: _____

Phone: (Cell) _____ (Work): _____ (Home) _____

Insurance Information

Primary

Name of Insured: _____ is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____

Signature of Patient, Parent or Guardian/Payment/Responsible Party

Relationship to Patient: _____

