

Encore Dental
Christopher Emma, D.M.D & Associates
185 Drum Point Rd.
Brick, N.J 08723
(732)202-7008
Fax#:(732)202-7947
encoredental@comcast.net

New Patient Information Form:

Date: _____ Patient Name: _____ D.O.B: _____

S.S #: _____ Address: _____

Home Phone #: _____ Cell#: _____

Email Address: _____ Parent/Guardian Name: _____

Primary Dental Insurance Plan: _____ Ins. Address: _____

Insurance Phone Number: _____

Subscriber Name: _____ Subscriber D.O.B: _____

Subscriber SS#: _____ Subscriber Ins. ID#: _____

Secondary Dental Insurance Plan: _____

Insurance Phone Number: _____ Ins. Address: _____

Subscriber Name: _____ Subscriber D.O.B: _____

Subscriber SS#: _____ Subscriber Ins. ID#: _____

Reason for
Appointment: _____

*Please bring with you to your appointment, fax or email us your form when complete.

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Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

Authorization:

I certify that I, have insurance coverage with, _____ and assign directly to Encore Dental all insurance benefits, if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on my insurance submissions. The above named dentist/entity may use my healthcare information and may disclose such information to the above named insurance company for the purposes of obtaining payment for services rendered.

Signature of Patient/Guardian: _____ Date: _____