Cherry Hill Dental Smiles

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Patient's Information

Patient's Name	Email	Social Security Number
Home Address	City, State, Zip	Birthdate
Marital Status ❑Single ❑Married ❑Divorced ❑Other	Gender ❑Male ❑Female ❑Other	Cell Phone
Driver License Number. Issuing State	Work Phone	Home Phone

Primary Dental Insurance Company Name	ID Number	Group Number
Name of Employer	Employer Address	Employer Telephone

Primary Dental Insurance Subscriber or Guardian's Information

If primary subscriber is different than guardian, please fill in primary subscriber's information below and check box here: ❑

Primary Subscriber or Guardian's Name	Email	Social Security Number
Home Address	City, State, Zip	Birthdate
Marital Status ❑Single ❑Married ❑Divorced ❑Other	Relationship to Patient	Cell Phone
Employer	Work Phone	Home Phone

How did you hear about our office or who referred you?

Patient's Dental History

Why have you come in to see us today?		
Previous Dentist	Last Visit	Date of Last Cleaning
Reason for changing dentist:		
Are you nervous about seeing a dentist? ❑Yes ❑No If yes, why?		
How often do you brush your teeth?	Do you floss? ❑Yes ❑No	How often do you floss?

Please check a box for each question below, even if the answer is 'No.'

❑Yes ❑No I take antibiotics before getting any dental work.
❑Yes ❑No I clench or grind my teeth during the day or while asleep.
❑Yes ❑No My gums bleed while brushing or flossing.
❑Yes ❑No I like my smile.
❑Yes ❑No I prefer tooth-colored fillings.
❑Yes ❑No I avoid brushing part of my mouth due to pain.
❑Yes ❑No My gums feel tender or swollen.
❑Yes ❑No I have problems eating.
❑Yes ❑No I have had orthodontics.
❑Yes ❑No I have had facial or jaw surgery.

Patient's Medical History

Do you have a history of any of the following? *Please check a box for each question below, even if the answer is 'No.'*

❑Yes ❑No Heart Disease
❑Yes ❑No Heart Murmur/Mitral Valve Prolapse
❑Yes ❑No Stroke
❑Yes ❑No Congenital Heart Lesions
❑Yes ❑No Rheumatic Fever
❑Yes ❑No Abnormal Blood Pressure
❑Yes ❑No Anemia
❑Yes ❑No Prolonged Bleeding Disorder
❑Yes ❑No Tuberculosis or Lung Disease
❑Yes ❑No Asthma
❑Yes ❑No Hay Fever
❑Yes ❑No Sinus Trouble
❑Yes ❑No Epilepsy/Seizures
❑Yes ❑No Ulcers
❑Yes ❑No Implants/Artificial Joints
❑Hip ❑Knee ❑Other
❑Yes ❑No I smoke or use tobacco.
If yes, how much per day?
For how many years?
❑Yes ❑No I have consumed alcohol within the last 24 hours.
❑Yes ❑No Have you ever taken Fen-Phen or Redux?
❑Yes ❑No I have had major surgery
Type of Operation:________________________ Year: ____________
Type of Operation:________________________ Year: ____________

❑Yes ❑No Liver Disease
❑Yes ❑No Jaundice
❑Yes ❑No Hepatitis Type _____
❑Yes ❑No Diabetes
❑Yes ❑No Excessive Urination and/or Thirst ❑Yes ❑No Infectious Mononucleosis (Mono)
❑Yes ❑No Herpes
❑Yes ❑No Arthritis
❑Yes ❑No Sexually Transmitted/Venereal Disease
❑Yes ❑No Kidney Disease
❑Yes ❑No Tumor or Malignancy
❑Yes ❑No Cancer/Chemotherapy
❑Yes ❑No Radiation Treatment
❑Yes ❑No History of Drug Addiction
❑Yes ❑No AIDS
❑Yes ❑No Immune Suppressed Disorder
❑Yes ❑No Hearing Loss
❑Yes ❑No Fainting Spells
❑Yes ❑No Glaucoma
❑Yes ❑No History of Emotional or Nervous Disorders ❑Yes ❑No Are you taking birth control medication?
❑Yes ❑No Are you or could you be pregnant or nursing?
❑Yes ❑No Do you have any other medical problem or medical history
❑Yes ❑No Coronavirus If yes, Date:__________________
NOT listed on this form? *(Please describe below.)*

Are you allergic to any of the following?

❑Yes ❑No Aspirin
❑Yes ❑No Ibuprofen
❑Yes ❑No Sulfa Drugs/Sulfites/Sulfides
❑Yes ❑No Penicillin
❑Yes ❑No Codeine
❑Yes ❑No Latex
❑Yes ❑No Metals, Plastics
❑Yes ❑No Local Anesthetics (Novocain)
❑Yes ❑No Other Medications?
Which ones?

Please list all medications you are currently taking or additional medical conditions you feel we should know.

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____
____
____
____
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Emergency Contact Information

Emergency Contact's Name	Emergency Contact's Phone	Relationship to Patient
Physician's Name	**Physician's** Phone	**Physician's** Location

Consent

I have answered all health questions to the best of my knowledge.
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Patient/Guardian's Signature: ____ Date: __________________

OFFICE USE ONLY

Witness Signature: ____ Date: __________________

Doctor's Signature: ____ Date: __________________