Dr. Michael Etter
Family & Cosmetic Dentistry

239-C Taunton Boulevard
Medford, NJ 08055
(856) 985-4646

New Patient Information Form

Reason for visit: _____

Name: _____ Sex: M __F__

Street address: _____

City: _____ State: ____ Zip: _____

Best phone number to contact: ( ) - Type: Home Work Cell

Patient Social Security #: _____-____-_____

Date of birth: ____/____/_____

Marital Status: Married__ Divorced__ Single__

Whom may we contact in case of emergency: _____

Phone: ( ) -

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Are you a full-time student? YES NO

Name of school if YES:_____

Person responsible for payment: _____

Relationship: _____

Street address: _____

City: _____ State: ____ Zip: _____

Best phone number to contact: ( ) - Type: Home Work Cell

DENTAL HISTORY

Date of last dental visit: ____/____/_____

Name of dentist: _____ City: _____ State: __

Circle any that apply. (Past or present history.)

Accidental injury to teeth/mouth Dental fractures

Swollen/tender/bleeding gums Tooth clenching/grinding

Lip/Cheek biting

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HEALTH HISTORY:

1. YES NO Is your general health good?
2. YES NO Has there been a change to your health within the last years?
3. YES NO Hospitalized or had a serious illness in the last 3 years?
   If YES, explain. _____
4. YES NO Are you being treated by a physician now?
   If YES, explain. _____
5. YES NO Are you in pain now?
6. YES NO Swollen ankles
7. YES NO Bleeding problems /bruise easily
8. YES NO Seizures
9. YES NO Excessive thirst
10. YES NO Dry mouth
11. YES NO Joint pain, stiffness
12. YES NO Heart disease
13. YES NO High blood pressure
14. YES NO Family history of diabetes, heart problems, tumors
15. YES NO AIDS
16. YES NO Kidney, Bladder disease
17. YES NO Diabetes
18. YES NO Thyroid, Adrenal
19. YES NO Pregnant or nursing?

Date of last medical exam: ____/____/_____

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Are you taking?

20. YES NO Recreational drugs? *If Yes, which ones?*_____

21. YES NO Prescriptions, supplements, or over-the-counter medications:
*If Yes, which ones?*_____

22. YES NO Tobacco in any form?

23. YES NO Birth Control Pills?

Do you have or have had any other disease/medical problems NOT listed?
If yes, explain._____

DENTAL INSURANCE INFORMATION:

Name of Dental Insurance policy holder: _____ Self ___

If you are NOT the subscriber, please answer the following questions:

Relationship to patient _____

Policyholder date of birth ____/____/_____

Policyholder Social Security # _____-____-_____

Policyholder's Place of Employment _____

If card is not present: Dental Insurance Carrier name_____

Phone ( ) -

Street address: _____

City: _____ State: ____ Zip: _____

Secondary insurance information: _____

_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____

Patient's signature *Date*