

**Dr. Michael Etter**  
Family & Cosmetic Dentistry

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

**New Patient Information Form**

Person responsible for payment: \_\_\_\_\_

Relationship: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Date of last dental visit: \_\_\_\_\_

Name of dentist: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other dry that apply. (Past or present history)

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Accidental injury to teeth/mouth \_\_\_\_\_ Dental traumas \_\_\_\_\_

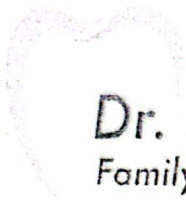
Marital Status: Married \_\_\_ Divorced \_\_\_ Single \_\_\_

Have you ever had bleeding gums \_\_\_\_\_ Teeth brushing/irritation \_\_\_\_\_

Other dental history

Whom may we contact in case of emergency: \_\_\_\_\_

Phone: ( ) -



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**HEALTH HISTORY:**

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*