

RICHARD P. NOBILE, D.D.S.  
417 EUCLID AVENUE  
SUITE A  
LOCH ARBOUR, NEW JERSEY 07711  
(732) 531-5333

DATE \_\_\_\_\_  
PATIENT'S NAME \_\_\_\_\_  
NAME OF SPOUSE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ PHONE# \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ CELL PHONE# \_\_\_\_\_  
PATIENT EMPLOYED BY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
SPOUSE EMPLOYED BY \_\_\_\_\_  
PURPOSE OF THIS APPOINTMENT \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_  
SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

**Primary Insurance**

NAME OF INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHONE# \_\_\_\_\_  
GROUP# \_\_\_\_\_ ID# \_\_\_\_\_  
INSURANCE COMPANY ADDRESS \_\_\_\_\_  
PHONE# \_\_\_\_\_

**Secondary Insurance**

NAME OF INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHONE# \_\_\_\_\_  
GROUP# \_\_\_\_\_ ID# \_\_\_\_\_  
INSURANCE COMPANY ADDRESS \_\_\_\_\_  
PHONE# \_\_\_\_\_

**For Women Only**

	YES	NO
Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, what month?.....		
Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?.....	<input type="checkbox"/>	<input type="checkbox"/>

**Dental History**

When was your last dental cleaning and exam? \_\_\_\_\_

Do you have a specific problem today?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, please note _____		
Do you have pain in or near your ears? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any growths or sore spots in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience bad breath?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontics? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated by a periodontist (Gum Specialist)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an extraction? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had difficulty with an extraction or prolonged bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed? .....	<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush? _____		
Do you use a manual or electric toothbrush? _____		
Do you floss? .....	<input type="checkbox"/>	<input type="checkbox"/>
How often? _____		
Do you use a special toothpaste or mouthwash? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, what kind? _____		
Do you drink coffee, tea or wine? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or chew tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>

WHOM MAY WE THANK FOR REFERRING YOU

Signature \_\_\_\_\_ Date \_\_\_\_\_

*DJR*

### Medical History

	YES	NO
Are you under any medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, what?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any major operations?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, what and when?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an accident involving head injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had adverse reaction to any drugs, including penicillin?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever informed you that you had:		
A Heart Ailment?.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever?.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism or Arthritis?.....	<input type="checkbox"/>	<input type="checkbox"/>
Tumors or Growths?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Blood Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Liver Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Kidney Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Stomach or Intestinal Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Venereal Disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV?.....	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice or Hepatitis?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats accompanied by weight loss or cough?...	<input type="checkbox"/>	<input type="checkbox"/>
Are you on a diet at this time?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any drugs or medications?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, what?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you need to premedicate before your dental visits?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, with what?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any known materials resulting in hives, asthma, eczema, etc?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you in general good health at this time?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have any wounds healed slowly or presented other complications?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of fainting?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any X-RAY TREATMENTS (other than diagnostic)?	<input type="checkbox"/>	<input type="checkbox"/>

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**Consent Form**

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs..
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_ . I understand that using anesthetic agents embodies a certain risk. furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other a arrangements have been made. In the event payments are not recieved by the agreed upon dates, I understand that a 1 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_