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

DATE ______________________

PATIENT'S NAME ______________________ DATE OF BIRTH: ______________

NAME OF SPOUSE ______________________

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# ______________

Medical History

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

For Women Only

	YES	NO
Are you pregnant?	❑	❑
If so, what month? ____________		
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

Dental History

When was your last dental cleaning and exam? ____________

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

WHOM MAY WE THANK FOR REFERRING YOU

Signature ____________ Date ____________

RICHARD P. NOBILE, D.D.S.
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(732) 531-5333

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. further-more, 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 ____

Richard P. Nobile, D.D.S.

417 Euclid Ave., Suite A
Loch Arbour, NJ 07711

Phone: (732) 531-5333

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ **Payment by cash**

___ **Payment by check**

___ **Payment by credit card**

___ **Automatic monthly billing to your Visa or MasterCard**

___ **Guarantee any amount not covered by insurance with Visa or MasterCard.**

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

____
Print your name here and sign below

*x*________________________________
*Date:*______________________________

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