WELCOME TO OUR OFFICE

Westfield Family Dentistry - Paul Arfanis DDS * 228 Saint Paul Street * Westfield, New Jersey 07090 * Phone no. (908) 232-0074 * www.westfieldDDS.com

Your Name:	Date:
What do you prefer to be called?	DOB:
Marital Status S M D W	

Home Address:		
City:	State:	ZIP Code:
Telephone:	Social Security Number:	
Cell Phone:	**E-mail Address:**	
Can we contact you by Email? Y / N	Can we contact you by Text Message? Y / N	
Occupation:	Telephone no.	
Employer:	Length of Employment:	
Employer's Address:		
City:	State:	ZIP Code:

Who should we thank for your referral:

PRIMARY CARE PHYSICIAN:	
Address:	Telephone no.

NAME OF SPOUSE:	
Occupation:	Social Security Number:
Employer:	Telephone no.

IN THE CASE OF AN EMERGENCY:

Contact:	Relationship:
Telephone no.	

COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE. (*)

Responsible Party:	Relationship:

(*) The patient and responsible party listed above hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles, which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient, which is not considered to be a covered service by third party insurers or payors. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% per month will be assessed on the unpaid balance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Note: (Waiver Clause) It is customary for our office to take photographs of our patients. Before and after pictures of dental work are kept for your records. Some of them may be utilized for publications, patient demonstration, and/or web site. Your confidence will be strictly observed. Please tell us if you would allow our office to utilize your photographs for publication.

_____YES, I do authorize Dr. Arfanis to publish my photographs
_____NO, I do not wish to publish my photographs.

To receive treatment in this office you must answer all questions on this history form.
The questions asked relate directly to the safe and effective treatment you are to receive in the office - to the best of your ability honest answers must be given.
If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.
Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided, but all questions must be answered.
To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is a “Permission to Release Information”. You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND ANY RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESSED AND WRITTEN PERMISSION.

PLEASE USE THE SPACE BELOW TO TELL US ANYTHING WE CAN DO TO HELP MAKE YOUR VISIT WITH US MORE COMFORTABLE:

1. a.) Name address & telephone # of your physician: _____
_____

b.) Do you see any medical specialists? _____

2. Date of last visit to your doctor_____ Purpose of visit_____

3. Do you suffer from any disability? _____ If yes, describe _____
_____

4.Do you take any drugs or medications? _____ if yes, list and describe amounts and purpose._____
_____

5. Have you ever had allergic reaction to medication? _____If yes describe_____
_____

6. Do you have, or have you ever had a skin reaction (Itching, swelling, crusting, redness, etc.) to jewelry? _____

7. Have you lost weight recently? _____If yes, please tell us the reason and how much weight you lost_____
_____

Have You Ever Had, Or Been Treated For:

8. Have you ever had or been treated for a heart infection?_____

9. Have you ever had heart surgery, had a heart valve replaced or repaired? ___ If yes, please explain_____

10. Have you ever or do you now take illegal drugs? _____ If yes, what drugs, and when taken_____

Note: *There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*

11. Do you have AIDS, or are you HIV - positive? _____If yes, describe and provide current status._____

12. Do you now have, or have you ever had a venereal disease? _____ If yes, describe._____

13. Have you ever had, or do you now have hepatitis? _____If yes, describe_____

14. **For our female patients**: Are you pregnant? _____ If yes, when are you due? _____

15.Are you taking birth control pills? _____

NOTE: *There are drugs and medications used in routine dental care that may reduce the effectiveness of contraceptives.*

16. Stomach or intestinal disease?_____

17. Abnormal blood pressure, excessive bleeding, or anemia?_____

18. Breathing problems: asthma, tuberculosis, or hay fever?_____

19. Cancer, X-ray treatments, or chemotherapy?_____

20. Diabetes or Hypoglycemia?_____ Does it occur in your immediate family?_____

21. Kidney problems or Renal Dialysis?_____

22. A stroke, convulsion, or fainting spells?_____

23.Tumors or growths?_____ _____

24. a.) Arthritis or rheumatism?_____

b.) Do you have any limitation to your ability to sit in a dental chair?_____

25. Have you ever had a major operation? If yes, describe_____

26. Have you ever had a serious injury to your head or neck? _____ If yes, describe_____
_____

27. Are you on a special diet?_____ If yes, for what reason and describe_____

28. Do you smoke? _____ If yes, describe type and quantity. _____

29. Are there any other problems about your health of which you are aware?_____

DENTAL HISTORY

Date of your last visit to a dentist_____ Reason for your last visit /or series of visits:
_____

With respect to any previous dental treatment have you:

30. Ever fainted?_____

31. Had abnormal bleeding?_____

32. Any other complications during or following dental treatment? _____ If yes, describe_____

33. Do your gums bleed on brushing or eating?_____ _____

34. Does food catch between your teeth?_____ _____

35. Have your teeth shifted	YES	NO
Are there spaces between your teeth now where there were none	YES	NO
Do your teeth-flare?	YES	NO
Are some of your teeth becoming loose?	YES	NO

36. Are any of your teeth sensitive to heat, cold, pressure or Chewing?_____

37. Do you have pain or clicking in the jaw joint next to ear? _____

38. Have your jaw muscles ever been sore?____ If yes, describe _____

39 Are there any sores or growths in your mouth?_____

40. Do any of your teeth ache ?_____

41. Do you have any other dental complaint?_____

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME.

To the best of my knowledge,, the foregoing questions have been accurately answered.

Signature:_____ Date: _____

Print Name:_____ Date: _____

If other than patient, indicate relationship _____

PERMISSION TO RELEASE HEALTH INFORMATION:

I grant the right to the dentist to release health information obtained from me, information about my dental treatment to third party payors, and/or other health practitioners.
Person completing the form:

Signature:_____ Date: _____

Print Name:_____ Date: _____

If other than patient, indicate relationship _____

Dentist's History Review & Significant Findings

_____

_____

_____

Signature Dr. Arfanis_____ Date ____/_____/_____