Patient Information

Stephen T Busby, DDS
169 Hobart Avenue, Short Hills, NJ 07078
(973) 376-5781

Date _____

Name _____ Home Phone (____) _____
Last First Middle

Address _____ Cell Phone (____) _____
Number, Street

City _____ State_____ Zip Code _____ Social Security No. _____

Occupation _____ Company Name _____ Business Phone ( )_____

Date of Birth ____/____/____ Sex M ☐ F ☐ Single ☐ Married ☐ Preferred Method of Contact Cell ☐ Home ☐ Business ☐ Email ☐
Mo Day Yr

Email _____ Name of Spouse/Significant Other _____ Emergency No. _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____ Closest Relative _____ Phone ( )_____

Patient Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes ☐ No ☐
2. Has there been any change in your general health within the past year? ..... Yes ☐ No ☐
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes ☐ No ☐
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes ☐ No ☐
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes ☐ No ☐
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease .... Yes ☐ No ☐
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes ☐ No ☐
      1. Do you have chest pain upon exertion? ..... Yes ☐ No ☐
      2. Are you ever short of breath after mild exercise or when lying down? ..... Yes ☐ No ☐
      3. Do your ankles swell? ..... Yes ☐ No ☐
      4. Do you have inborn heart defects? ..... Yes ☐ No ☐
      5. Do you have a cardiac pacemaker? ..... Yes ☐ No ☐
   c. Allergy ..... Yes ☐ No ☐
   d. Sinus Trouble ..... Yes ☐ No ☐
   e. Asthma or hay fever ..... Yes ☐ No ☐
   f. Fainting spells or seizures ..... Yes ☐ No ☐
   g. Persistent diarrhea or recent weight loss ..... Yes ☐ No ☐
   h. Diabetes ..... Yes ☐ No ☐
   i. Hepatitis, jaundice, or liver disease ..... Yes ☐ No ☐
   j. AIDS or HIV infection ..... Yes ☐ No ☐
   k. Thyroid problems ..... Yes ☐ No ☐
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes ☐ No ☐
   m. Arthritis or painful swollen joints ..... Yes ☐ No ☐
   n. Stomach ulcer or hyperacidity ..... Yes ☐ No ☐
   o. Kidney Problems ..... Yes ☐ No ☐
   p. Tuberculosis ..... Yes ☐ No ☐
   q. Persistent cough or cough that produces blood ..... Yes ☐ No ☐
   r. Persistent swollen glands in neck ..... Yes ☐ No ☐
   s. Low blood pressure ..... Yes ☐ No ☐
   t. Sexually transmitted disease ..... Yes ☐ No ☐

u. Epilepsy or other neurological disease ..... Yes ☐ No ☐
v. Problems with mental health ..... Yes ☐ No ☐
w. Cancer ..... Yes ☐ No ☐
x. Problems of the immune system ..... Yes ☐ No ☐

9. Have you ever had abnormal bleeding? ..... Yes ☐ No ☐
   a. Have you ever required a blood transfusion? ..... Yes ☐ No ☐
10. Do you have any blood disorder such as anemia? ..... Yes ☐ No ☐
11. Have you ever had any treatment for a tumor or growth? ..... Yes ☐ No ☐
12. Are you allergic or have you had an allergic reaction to:
    a. Local anesthetics ..... Yes ☐ No ☐
    b. Penicillin or other antibiotics ..... Yes ☐ No ☐
    c. Sulfa Drugs ..... Yes ☐ No ☐
    d. Barbiturates, sedatives, or sleeping pills ..... Yes ☐ No ☐
    e. Aspirin ..... Yes ☐ No ☐
    f. Codeine or other narcotics ..... Yes ☐ No ☐
    g. Other _____
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes ☐ No ☐
    a. If so, explain _____
    b. Do you have any disease, condition, or problem not listed above that you think I should know about?.. Yes ☐ No ☐
    c. If so, explain _____
14. Are you wearing contact lenses? ..... Yes ☐ No ☐
15. Are you wearing removable dental appliances? ..... Yes ☐ No ☐

Women

17. Are you pregnant? ..... Yes ☐ No ☐
18. Do you have any problem associated with you menstrual period? ..... Yes ☐ No ☐
19. Are you nursing? ..... Yes ☐ No ☐
20. Are you taking birth control pills? ..... Yes ☐ No ☐

Chief Dental Complaint_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

Primary Insurance Information

Person Responsible for Account _____ Date of Birth ____ /____/____
(Last, First, Middle) (Mo, Day, Yr)

Relation to Patient _____ Social Security No. _____ Home Phone ( )_____

Address _____ Cell Phone ( )_____
(Number, Street)

City _____ State _____ Zip Code _____ Email _____

Person Responsible Employed by _____ Occupation _____ Business Phone ( )_____

Business Address _____ Business Email _____

Insurance Company _____ Phone ( )_____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan_____

Is patient covered by any additional insurance? Yes ☐ No ☐ _____