SONG
GENERAL.COSMETIC.IMPLANT

Song Dental
16 Central Ave Tenafly NJ 07670
Tel: 201-227-0040
www.songdentalnj.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:	

Best places and times to contact you:	Send appointment reminders via: Text Message Email Mail

Please tell us where you heard about us (check all that apply):

Friend or Relative Newspaper Ad Radio Ad TV Ad Ad in Mail Saw our Office
Insurance Company Our Website Search Engine (Google, etc.)
Other Website: Other:

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:	

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Emergency_Contact Address:	City:	State:	ZIP Code:

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Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

Insurance Information

Primary Insurance

Insurance Holder's Name:	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Naomi Ram & Shahram Shamloo to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Naomi Ram & Shahram Shamloo. I permit a copy of this authorization to be used in place of the original. I give Naomi Ram & Shahram Shamloo, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):	Driver's Licence State & #:
	/ /	

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Consent for Treatment

Patient Name:	

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Phone: - -	Last Visit: /	

Address:	City:	State:	ZIP Code:

Do we have permission to contact your doctor regarding your care? Yes No

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Have you ever had:

Check all that apply.

- Arthritis
- Arteriosclerosis
- Birth defects
- Cancer
- Emotional problems
- Head or face injury
- Heart murmur/trouble
- History of substance abuse/drug addiction
- Kidney problems
- Numbness of arms or hands
- Swollen, still painful joints
- Allergies
- Asthma
- Blood disease
- Diabetes
- Endocrine problems
- Intestinal disorders
- Hepatitis a, b, or c
- Hypertension (high blood pressure)
- Liver problems
- Pneumonia
- Shortness of breath
- Anemia
- Bruise easily
- Dizziness
- Epilepsy
- Seizures
- Fainting
- Hearing disorders
- High or low blood sugar
- Hypotension (low blood pressure)
- Nervous disorder
- Rheumatic fever
- Heart attack/stroke
- Heart surgery
- Pacemaker
- Artificial valves
- Congenital heart defect
- Mitral valve prolapse
- Artificial bones/joints
- Shingles
- HIV/AIDS
- Blood transfusions
- Fever blisters
- Sinus problems
- Severe/frequent headaches
- Cancer/chemotherapy
- Radiation treatments
- Psychiatric problems
- Tuberculosis
- Venereal disease
- Hemophilia
- Abnormal bleeding
- Ulcers/colitis
- Difficulty breathing
- Hospitalized for any reason
- Emphysema
- Glaucoma
- Thyroid disease
- Angina
- Artificial hip/joints
- Gout
- Chest pain
- Circulatory problems
- Cold sores
- Congenital heart lesion
- Cortisone medicine
- Convulsions
- Herpes
- Leukemia
- Excessive thirst
- Hay fever
- Heart disease
- Hives/skin rash
- Hypoglycemia
- Irregular heartbeat
- Lung disease
- Osteoporosis
- Pain in jaw joints
- Parathyroid disease
- Recent weight loss
- Rheumatism
- Scarlet fever
- Sexually transmitted disease
- Sickle cell anemia
- Sinus trouble
- Tattoos/body piercing
- TMD/TMJ (jaw pain)
- X-ray or cobalt treatment
- Yellow jaundice
- Chronic fatigue syndrome
- Cough-persistent or bloody
- Latex sensitivity
- Smoker
- Swelling of feet/ankles
- Swollen neck glands
- Tonsillitis
- Tumor or growth on head/neck
- Easily winded
- Anaphylaxis
- Alzheimer's disease
- Frequent diarrhea
- Genital herpes
- Renal dialysis
- Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- Acrylic
- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Dental anesthetics
- Erythromycin
- Iodine
- Latex rubber
- Metals
- Nitrous oxide
- Novocaine
- Penicillin/antibiotics
- Sedatives
- Sulfa drugs
- Tetracycline
- Valium
- Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No

Do you take or have you taken Phen-Fen or Redux? Yes No

Do you smoke or chew tobacco? Yes No

Do you use alcohol, cocaine, or other drugs? Yes No

Do you wear contact lenses? Yes No

Are you on a special diet? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you use more than two pillows to sleep? Yes No

Have you ever had any excessive bleeding requiring special treatment? Yes No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No

Have you been treated in a hospital in the last five years? Yes No

If female, please mark if you are:

Pregnant - If so, please enter your due date or week #:

Trying to get pregnant Nursing On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? Yes No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /	Driver's Licence State & #:

For office use:

Reviewed by: Title: Date: / /

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Our Office

What do you already know about our office and what are your expectations?

What would it take for you to trust us to be your dentist?

We can look at your mouth from 3 different perspectives. This will help us determine how to best treat you and your specific dental needs. What combination of these would you like us to use for your situation?

As a general dentist As a cosmetic dentist As a functional (bite, TMJ) dentist

At what point do you want us to initiate treatment for you?

When something isn't ideal When something worsens When my tooth hurts or breaks