Toms River Smiles Dental
941 Route 37 W #5
Toms River, NJ 08755
732-244-1163
www.trsmiles.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 Information

First Name:	Middle Name:	Last Name:

Sex:	Age:	Date of Birth (mm/dd/yyyy):	Social Security #:
		/ /	- -

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

Home Address:	City:	State:	ZIP Code:

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

❑ Friend or Relative (name): ❑ Saw our Office ❑ Insurance Company
❑ Our Website ❑ Other Website: ❑ Other:

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:
- -	- -	- -

Toms River Smiles Dental
941 Route 37 W #5
Toms River, NJ 08755
732-244-1163
www.trsmiles.com

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

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

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	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 Toms River Smiles Dental to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Toms River Smiles Dental. I permit a copy of this authorization to be used in place of the original. I give Toms River Smiles Dental, 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): / /

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): / /

Toms River Smiles Dental
941 Route 37 W #5
Toms River, NJ 08755
732-244-1163
www.trsmiles.com

Dental History

Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Discolored	❑ Sensitive to cold
❑ Decay	❑ Missing teeth	❑ Sensitive to heat
❑ Difficulty chewing	❑ Mouth sores	❑ Sensitive when biting

Gums

❑ Bad breath	❑ Abscessed	❑ Sore	❑ Receding
❑ Red (discolored)	❑ Bleeding	❑ Swollen	❑ Periodontal treatment

Miscellaneous

Has the cost of dental treatment been a concern for you? ❍Yes ❍No

If yes, how can we help?

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

Medical History

How is your general health? ❍Good ❍Fair ❍Poor

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

Yes

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

Yes

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

Address:	City:	State:	ZIP Code:

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

Toms River Smiles Dental
941 Route 37 W #5
Toms River, NJ 08755
732-244-1163
www.trsmiles.com

Have you ever had:

Check all that apply.

- ❑ Arthritis
- ❑ Cancer
- ❑ Heart murmur/trouble
- ❑ History of substance abuse/drug addiction
- ❑ Allergies
- ❑ Diabetes
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Shortness of breath
- ❑ Anemia
- ❑ Epilepsy
- ❑ Hypotension (low blood pressure)
- ❑ Heart attack/stroke
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Mitral valve prolapse
- ❑ HIV/AIDS
- ❑ Cancer/chemotherapy
- ❑ Tuberculosis
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Ulcers/colitis
- ❑ Hospitalized for any reason
- ❑ Thyroid disease
- ❑ Angina
- ❑ Chest pain
- ❑ Herpes
- ❑ Heart disease
- ❑ Hives/skin rash
- ❑ Parathyroid disease
- ❑ Sexually transmitted disease
- ❑ Sinus trouble
- ❑ Cough-persistent or bloody
- ❑ Smoker
- ❑ Swelling of feet/ankles
- ❑ Tumor or growth on head/neck

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

Toms River Smiles Dental
941 Route 37 W #5
Toms River, NJ 08755
732-244-1163
www.trsmiles.com

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

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

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

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): / /

For office use:
Reviewed by: Title: Date: / /