Princeton Dentistry
Payam Hanian, DMD

601 Ewing Street, Suite C16
Princeton, New Jersey 08540

Patient Information

Date _____/_____/_____ Social Security # _____-____-_____

☐ Male ☐ Female Date of Birth _____/____/_____

Patient Name: ______________________________
Last Name First Name Initial

I preferred to be called by *my Nickname*: ______________________

Address: ______________________________

City: ______________________ State____ Zip___________

E-Mail Address: __________________@__________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation:______________________________ ☐ Student
☐ F/T College

Patient Employer/School ______________________
Address: ______________________
Telephone: ______________________

Parent/Guardian: ______________________________
Last Name First Name Initial

OR

Spouse's Name: ______________________________
Last Name First Name Initial

Date of Birth: _____/___/_____ Social Security # _____-____-_____

Spouse's Employer: ______________________________

Other Family Members/Relatives We See In Our Practice:

______________________ ______________________

______________________ ______________________

Phone Numbers

Home # (____)_____-_________ Pharmacy # (___)____-______

Work # (____)_____-_________ Ext ___

Cell # (____)_____-_________

Spouse's Wk# (____)_____-_________ Ext ___

Spouse's Cell # (____)_____-_________

In case of Emergency, please call ____________________Relation

Wk (____)_____-_________ Hm (____)_____-_________

X____

Signature of Responsible Party 1) ***I do not have insurance*** coverage and agree to pay in full for all charges at the time services are rendered; *or* ***2) All Insurance co-payments*** are due at time services are rendered. In case of non-payment by your insurance company, you will be responsible for payment in full.

Responsible Party Information

Responsible Party ______________________________
Last Name First Name Initial

Relation to patient: ______________________________

Address (*If different from Patients*): ______________________

City __________________ State_______ Zip____________

Home # (____)_____-_________

Work # (____)_____-_________ Ext ___

Mobile# (____)_____-_________

Dental Insurance Information PRIMARY

Insured: ______________________________
Last Name First Name Initial

Insured Social Security # ____-____-____

Dental ID# ____________

Insured's Date Of Birth: ____-____-____

Dental Ins. Company :______________________

Dental Ins. Claim Address: ______________________

City______________________ State_______ Zip ________

Dental Ins. Telephone # (_____) ______________

Group # ______________ Effective Date: ___________

Employer:______________________________

Employer Address ______________________

City_________ ST____ Zip ________ Wk#(____)_________

Dental Insurance Information SECONDARY

Insured: ______________________________
Last Name First Name Initial

Insured Social Security # ____-____-____

Dental ID# ____________

Insured's Date Of Birth: ____-____-____

Dental Ins. Company: :______________________

Dental Ins. Claim Address: ______________________

City__________________ State_______ Zip ___________

Dental Ins. Telephone # (_____) ______________

Group # ______________ Effective Date: ___________

Employer:______________________________

Employer Address ______________________

City_________ ST____ Zip ________ Wk#(____)_________

Who May We Thank For Referring You To Us?

Name:

____

Please Complete Other Side of This Form ➔➔➔

Dental History

Reason for Today's Visit: ______________________________ Previous Dentist: ___________________________________

Date of Last Dental X-Rays: ____________________________ Date of Last Dental Visit: _____________________________

Medical History

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions*

Physician's Name: __________________________ Telephone# ____________________ Date of Last Visit: ______________

Pharmacy Name: ___________________________ Telephone# ____________________

☐ I am currently under care for a specific medical condition? _________What Condition?___________________________________

☐ I am currently taking prescription or over-the-counter medications. **LIST MEDICATIONS TAKING**:__________________________

____

Have you been hospitalized? If so, what was the reason? ____

____

☐ Currently, are you on a special diet? If so, what type of diet? ____

☐ I use tobacco ☐ I use controlled substances: ____

☐ I had (have) a serious head or neck injury. Describe:____

☐ I wear contact lenses ☐ I am Pregnant ☐ I am Nursing ☐ I take oral contraceptives

☠ Are You Allergic To Any Of The Following? *☠*

☐ Acrylic ☐ Aspirin ☐ Barbiturate (sleeping pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Metal

☐ Penicillin ☐ Sulfa ☐ Other ____

➜ ***Please mark an "X" next to any of the following medical conditions that apply:*** ➜ **Condition May Require Medication

☐ AIDS/HIV	☐ Diabetes	☐ Pain in Jaw Joints
☐ Alzheimer's Disease	☐ Emphysema or Easily Winded	☐ Pacemaker **
☐ Anaphylaxis	☐ Epilepsy / Seizure / Convulsions	☐ Psychiatric Care
☐ Anemia	☐ Excessive Thirst	☐ Radiation Treatment
☐ Angina	☐ Fainting or Dizziness (Ringing in Ear)	☐ Respiratory Disease
☐ Arthritis / Rheumatism / Gout	☐ Glaucoma	☐ Rheumatic Fever **
☐ Artificial Heart Valve(s)	☐ Headaches / Migraine	☐ Scarlet Fever **
☐ Artificial Joint Replacement(s)	☐ Heart Murmur – Regurgative **	☐ Shingles
☐ Asthma	☐ Heart Problems / Disease	☐ Sickle Cell Disease
☐ Back Problems	☐ Hepatitis – Type _____	☐ Sinus Trouble
☐ Bleeding Abnormally (extractions/surgery)	☐ Herpes	☐ Spina Bifida
☐ Blood Disease / Transfusion(s)	☐ High Blood Pressure	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Hypoglycemia	☐ Stroke
☐ Cancer	☐ Irregular Heartbeat	☐ Swollen Feet or Ankles
☐ Chemical Dependency	☐ Jaundice	☐ Swollen Neck Glands
☐ Chemotherapy	☐ Jaw Pain	☐ Thyroid Disease
☐ Chest Pains	☐ Kidney Disease	☐ Tonsillitis
☐ Cold Sores/Fever Blisters	☐ Leukemia	☐ Tuberculosis
☐ Congenital Heart Disorder	☐ Liver Disease	☐ Tumor or Growth
☐ Cortisone Medication	☐ Low Blood Pressure	☐ Ulcer
☐ Cough, Persistent or Bloody	☐ Lung Disease	☐ Venereal Disease
	☐ Mitral Valve Prolapse **	☐ Weight Loss, Unexplained

Any serious illness not listed above? Please explain: ____

To the best of my knowledge, the questions on this form have been accurately answered. 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.

Disclaimer: Insurance coverage is only a estimation. Guarantor is responsible for all treatment not covered by insurance.

X____ ____________________

Signature of Patient, Parent, Guardian Date

X_________________________

Payam Hanian, DMD