Ocean Dental Associates

1201 Route 37 East - Toms River NJ 28753 - Phone (732) 929 2250 - Fax (732) 929 0387

PATIENT INFORMATION

Last Name: First: Middle:

Cell Phone: ( ) Email:

Address:
Mailing Address

DOB: / / Gender: Marital Status:

Occupation: Patient's Employer/School:

Employer/School #: ( ) Employer/School Address:

Emergency Contact: Relationship: Phone: ( )

DENTAL HISTORY

Please place a mark on "yes" or "no to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Bad breath	☐	☐	Lip or cheek biting	☐	☐	Sensitivity when biting
☐	☐	Bleeding gums	☐	☐	Mouth breathing	☐	☐	Sores or growths in mouth
☐	☐	Blisters on lip/mouth	☐	☐	Mouth pain, brushing	☐	☐	Loose teeth or broken fillings
☐	☐	Dry mouth	☐	☐	Orthodontic treatment	☐	☐	Food collection between teeth
☐	☐	Fingernail biting	☐	☐	Pain around ear	☐	☐	Clicking or popping jaw
☐	☐	Foreign objects	☐	☐	Periodontal treatment	☐	☐	Cigarette/Pipe/Cigar smoking
☐	☐	Grinding teeth	☐	☐	Sensitivity to sweets	☐	☐	Chew on one side of mouth
☐	☐	Gums swollen/tender	☐	☐	Sensitivity to heat	☐	☐	Burning sensation on tongue
☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to cold	☐	☐	Other: _____

Reason for Today's Visit:

Former Dentist: City/State:

Date of Last Dental Visit: / / Date of Last Dental X-Rays: / /

DENTAL INSURANCE

Insurance Subscriber: Relationship to Patient:

Insurance Company: Subscriber DOB: / /

PRE-MEDICATION

Do you take antibiotics prior to your dental treatment? *Yes* ☐ *No* ☐

Name & dosage: _____

Reason: _____

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MEDICAL INFORMATION

Please check yes or no. If you do not know, leave it blank.

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial Heart Valve	☐	☐	Lupus/Erythematosus	☐	☐	Kidney problems
☐	☐	Heart murmur/MPV	☐	☐	Cancer/Chemotherapy	☐	☐	Joint replacement
☐	☐	High cholesterol	☐	☐	Eating disorder	☐	☐	Diabetes Type _____
☐	☐	Abnormal bleeding	☐	☐	Hepatitis/Liver Disease	☐	☐	Mental disorder
☐	☐	Stomach problems	☐	☐	Seizure	☐	☐	Congestive Heart Failure
☐	☐	Stroke	☐	☐	Sleep apnea	☐	☐	AIDS/HIV
☐	☐	Heart Attack	☐	☐	Snoring	☐	☐	Rheumatic fever
☐	☐	Angina	☐	☐	Low blood pressure	☐	☐	(Rheumatoid) arthritis
☐	☐	Damaged heart valve	☐	☐	High blood pressure	☐	☐	Emphysema
☐	☐	Heart surgery	☐	☐	Asthma/Bronchitis	☐	☐	Excessive urination
☐	☐	Pacemaker	☐	☐	Radiation	☐	☐	Gastrointestinal issues
☐	☐	Anemia/Hemophilia	☐	☐	Ulcer	☐	☐	Thyroid problem
☐	☐	Osteoporosis	☐	☐	Headaches/Migraines	☐	☐	Night sweats
☐	☐	Endocarditis	☐	☐	Glaucoma	☐	☐	Recurrent infections
☐	☐	Autoimmune disease	☐	☐	Recent weight gain/loss	☐	☐	Neurological disorder
☐	☐	Tuberculosis	☐	☐	Smoking/Chewing tobacco	☐	☐	Congenital heart defect
☐	☐	Epilepsy	☐	☐	Heart disease	☐	☐	Other: _____

Are you currently on blood thinners? *Yes* ☐ *No* ☐

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®), for osteoporosis or Paget's disease?

Yes ☐ *No* ☐

Since 2001, were you treated or are you presently scheduled to being treatment with the intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?

Yes ☐ *No* ☐ *Treatment began:* / /

Please explain "yes" answers: _____

_____

Do you have any diseases, conditions, or problems not listed above that you think your dentist should know about?

_____

_____

For Women

Are you pregnant? *Yes* ☐ *No* ☐ Due Date: _____ *Are you nursing?* *Yes* ☐ *No* ☐

Taking birth control pills? *Yes* ☐ *No* ☐

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Latex

☐ Others: _____

_____

_____

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Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for schedules appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read, mark, & initial the items below and sign at the bottom of the form.

1. **Treatment to be provided**

I understand that during my course of treatment, the following care may be provided:

☐ Examinations Preventive Services ☐ Restorations ☐ Crowns Bridges ☐ Other

Patient's Initials: _____

2. **Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, causing redness and swelling of the tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient's Initials: _____

3. **Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient's Initials: _____

4. **I give permission** to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient's Initials: _____

_____

Signature of Patient ***Print Name*** ***Date***

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Cancellation & No Show Fee Office Policy

We understand that patients may need to cancel or reschedule appointments. To provide effective and efficient treatment to all our patients, it is the office policy that all appointment cancellations (including rescheduling) must be made at least 24 hours prior to your appointment time. Appointment times are limited; therefore cancelling in advance will allow us to bring in someone else who needs to be seen on an emergent basis. If you do not cancel 24 hours in advance, you will be charged a $50 fee. *As this fee is not billed to any insurance company, the patient accepts full responsibility to pay this fee.*

Signature: _____ Date: _____

PRIVACY ACKNOWLEDGEMENT

I have received the **Notice of Privacy Practice** and I have been provided an opportunity to review it.

Name: _____ DOB: _____

Signature: _____ Date: _____

Please list any family members or other individuals below that you allow us to speak to or access your records.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any additional information you would like Dr. Bui to know:

_____

_____

_____

I, the patient of Ocean Dental Associates of Toms River, understand everything I have signed. I understand my rights and understand that my information is private. If I have further questions, I can speak to Dr. Bui or a staff member.

_____

Signature of Patient ***Print Name*** ***Date***