Harmony Dental Arts
www.NJPerfectSmile.com
1066 Clifton Avenue **Tel 973-777-2731**
Clifton, NJ 07013 **Fax 973-777-1077**

PATIENT INFORMATION:

Name: _____ DOB: _____ SS#: _____

Mailing Address: _____City, State, Zip: _____

Home #: _____ Work #: _____Cell #: _____

EMAIL: _____

EMPLOYER & Address: _____

ACCOUNT RESPONSIBILITY if someone other than yourself:

Name: _____ DOB: _____ SS#: _____

Mailing Address: _____City, State, Zip: _____

Whom may we thank for referring you? : _____

Reason for today's visit: _____

DENTAL INSURANCE:

Name of Ins. Company: _____

If you are not the primary policy holder, please enter policy holder's information below:

Name: _____ DOB: _____ SS#: _____

EMPLOYER & Address: _____

NOTICE OF PRIVACY PRACTICE: The privacy of your health information is important to us. During your initial visit, please review the notice of privacy practices regarding uses and disclosures of your health information.
INSURANCE POLICY: If you have dental insurance, we will send the claim electronically for you, and have the reimbursement sent directly to Harmony Dental Art. We will estimate your portion and ask that you take care of it at the time of service. Any balance remaining after insurance pays is the responsibility of the patient.

DENTAL HISTORY:

Bad Breath	?áYes ? No	Bleeding Gums	?áYes ? No	Clicking/ Popping Jaw	?áYes ? No
Jaw Pain	?áYes ?bNo	Orthodontic Treatment	?áYes ?bNo	Periodontal Treatment	?áYes ?bNo

HEALTH HISTORY:

AIDS/HIV?áYes ?§No	Chemotherapy ?áYes ?§No	Mitral Valve Prolapse ?áYes ?§No
Arthritis ?áYes ? No	Congenital Heart Lesions ?áYes ? No	Oral Herpes ?áYes ? No
Artificial Heart Valves ?áYes ?bNo	Cough (Persistent/Bloody) ?áYes ?bNo	Pacemaker ?áYes ?bNo
Artificial Joints ?áYes ?•No	Diabetes ?áYes ?•No	Psychiatric Care ?áYes ?•No
Asthma ?áYes ?@No	Epilepsy ?áYes ?@No	Rheumatic Fever ?áYes ?@No
Blood Disease ?áYes ?ùNo	Heart Murmur ?áYes ?ùNo	Smoking ?áYes ?ùNo
Blood Pressure ?áYes ?³No	Heavy Bleeder ?áYes ?³No	Tuberculosis ?áYes ?³No
Cancer ?áYes ?t No	Hepatitis (Type _____) ?áYes ?t No	Other ?áYes ?t No
Chemical Dependency ?áYes ?. No	Kidney/Liver Disease ?áYes ?. No	Please list other: _____

List any and all **ALLERGIES**: ?áCodeine ?áLatex ?áLocal ?áAnesthetic ?áPenicillin ?áOther _____

List any and all **DRUGS/MEDICATIONS** you are taking:

_____

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____

DATE: _____