Richard Mann, D.M.D.
95 Madison Avenue
Suite 100
Morristown, NJ 07960
(973)984-3300
www.richardmann.com
richardmanndmd@gmail.com

Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

RESPONSIBLE PARTY, if other than patient, or if patient is child under 18 years.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

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Primary Dental Insurance:

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Secondary Dental Insurance

Name of Insured: Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Subscriber ID or Social Security Number

Subcriber D.O.B.

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- [ ] *PREMEDICATE
- [ ] AIDS/HIV +
- [ ] Alcohol abuse
- [ ] Allergies
- [ ] Allergy anesthesia
- [ ] Allergy Asprin
- [ ] Allergy Sulfa
- [ ] Allergy Keflex
- [ ] Allergy Alcohol
- [ ] Allergy Codeine
- [ ] Allergy Erythromycin
- [ ] Allergy Penicillin
- [ ] Allergy Tetracycline
- [ ] Allergy to Codeine
- [ ] Allergy to Latex
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Drug abuse
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] Herpes,fever Blister
- [ ] High Blood Pressure
- [ ] Hormone Tx
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lupus
- [ ] Major Hospitalizatio
- [ ] Mental Disorders
- [ ] Mitral Valve Pro
- [ ] Nervous Disorders
- [ ] No EPINEPHERINE
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnant
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Smoker/tobacco User
- [ ] Steroids/cortisone
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

If any conditions or alerts selected above needs further clarification, please describe below:

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

Have you had any reaction to local anesthetics in the past?

- ◯ Yes
- ◯ No

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List all medications, supplements, and/or vitamins taken within the last two years:

AUTHORIZATION

* ☐ By checking this box, I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

* ☐ By checking this box, I authorize release of my information concerning my (or my child's) healthcare, advice and treatment to another dentist.

* ☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits issued.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all changes whether or not paid by insurance.

* ☐ By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* ☐ I have read a copy of the office's Notice of Privacy. I am aware that I may retain a copy of this notice.

PATIENT, PARENT or GUARDIAN SIGNATURE

Signature: _____ Date:

Response Date: