Date:_____

DENTAL CARE

Andrew D. Meyers, DDS
Margaret H. Sullivan, DDS
2124 Highway 35 • Holmdel, NJ 07733
732.671.8866

Welcome

We are pleased that you have chosen to come to this office for your dental care, and we want you to know that your oral health is our primary concern. Our goal is to help you achieve the highest level of oral health so that your teeth and your smile will be preserved and protected for a lifetime. Remember that we are here to help YOU. If you have any special problems or concerns, please feel free to discuss them with the Doctors.

Each patient is personally important to us. If you were referred to us by someone, please give their name in the space below so that we may thank them. Also, we will be happy to welcome any friends or acquaintances of yours who may be in need of dental care.

Patient Information:

Last Name: _____ First Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Birth date: _____

Relationship to Guarantor (Person Responsible for Account)

Circle one: Self Spouse Child Other

Are you: Married Single Divorced Widowed

Referred by: _____

Guarantor: (Person Responsible for Account)

Miss Ms Mr Mrs Dr

Last Name: _____ First Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Birth date: _____

Social Security #: _____

Employer: _____ Employer's address: _____

Group #: _____ Work Phone/ext: _____

Insurance (Guarantor's Insurance)

Dental Insurance: _____ Policy Number: _____

Address: _____

Spouse: (Fill out only if there is a second insurance)

Last Name: _____ First Name: _____

Social Security #: _____ Birth date: _____

Employer: _____ Employer's address: _____

Group #: _____ Work Phone/ext: _____

Insurance (Spouse's Insurance)

Dental Insurance: _____ Policy Number: _____

Address: _____

Patient's Dental Information

What is the purpose of your visit? (Please check)
__ Regular checkup and cleaning
__ Particular Problem Please describe _____

What do you use to clean your teeth?

__ Toothpaste
__ Dental Floss
__ Toothpicks or Stimulants
__ Inter proximal Brushes
__ Other _____

How often do you clean your teeth? _____

Do your gums bleed when you brush? __ Yes __ No

Are any of your teeth sensitive to hot or cold or sweet things? __ Yes __No

Do you clench or grind your teeth during the day or night? __ Yes __ No

Do any teeth seem loose? __ Yes __ No

Are you happy with the appearance of your teeth? __ Yes __ No

Are you aware of any sores in your mouth? __ Yes __ No

Patient's Medical History

An Accurate medical history is important for thorough dental care. Please indicate your answers to the following questions. This information is for our records only and will be held in strict confidence.

Your Physician's name: Dr. _____

Address: _____

Have you been under a physician's care during the past year? __Yes __ No

For what condition? _____

Have you been hospitalized within the past 5 years? __ Yes __ No What condition? _____

Do you have or have you had any of the following? (Check all that apply)

__ Rheumatic Fever	__ Hepatitis, Jaundice	__ Congenital Heart Lesions
__ Arthritis, Rheumatism	__ Heart or Vascular Disease	__ Stomach Ulcers
__ Stroke	__ Kidney Trouble	__ High Blood Pressure
__ Sinus Trouble	__ Venereal Disease	__ Fainting Spells or Seizures
__ Persistent Cough	__ Bleeding Tendencies	__ Tumors
__ Diabetes	__ AIDS	__ Other _____

Are you allergic or have you reacted adversely to

__ Local Anesthetics	__ Aspirin	__ Penicillin, Antibiotics
__ Iodine	__ Sulfa Drugs	__ Codeine, Narcotics
__ Barbiturates, Sedatives	__ Other _____	

Is there any other condition or problem not listed above that you think the doctor should know about?

__ Yes __ No Describe: _____

Women: are you pregnant? __ Yes __ No Due Date: _____

Method of payment: __ Cash __ Check __MasterCard/Visa

Patient's Signature: _____