Leanne Mitchell, D.M.D.
621 Mullica Hill Road
Richwood, NJ 08074

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

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Patient Information

Date

Name | Date of Birth | SS#

Street | City | State | Zip

Email | Home Phone | Cell Phone

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of School or College (if student) | City | State | ☐ Part-time ☐ Full-time

Patient or Parent/Guardian's Employer | Work Phone

Business Address | City | State | Zip

Spouse or Parent/Guardian's Name | Employer | Work Phone

If you were referred, whom may we thank? | Emergency Contact | Contact's Phone

Responsible Party

Name of Person Responsible for This Account | Relationship to Patient

Street | City | State | Zip

Email | Home Phone | Cell Phone

Driver's License | Date of Birth | Financial Institution

Employer | Work Phone | SS#/ SIN

Is this person currently a patient in our office? ☐ YES ☐ NO

For your convenience, we offer the following methods of payment. Please check the options you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured | Relationship to Patient

Date of Birth | SS#/ SIN | Date of Employment

Name of Employer | Union or Local # | Work Phone

Employer Address (Street) | City | State | Zip

Insurance Company | Group # | Policy/ ID #

Insurance Company Address (Street) | City | State | Zip

How much is your deductible? | How much have you used? | Maximum Annual Benefit

** If you have additional insurance, please enter the information below.*

Name of Insured | Relationship to Patient

Date of Birth | SS#/ SIN | Date of Employment

Name of Employer | Union or Local # | Work Phone

Employer Address (Street) | City | State | Zip

Insurance Company | Group # | Policy/ ID #

Insurance Company Address (Street) | City | State | Zip

How much is your deductible? | How much have you used? | Maximum Annual Benefit

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Patient Medical History

Physician | Office Phone | Date of Last Exam

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	YES	NO
1) Are you under medical treatment now?	☐	☐
2) Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain: _____		
3) Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4) Do you use tobacco?	☐	☐
5) Do you use controlled substances?	☐	☐
6) Are you wearing contact lenses?	☐	☐

8) Are you allergic to or have you had any reactions to the following?	YES	NO
Local anesthetics (e.g. novocaine)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbituates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex rubber	☐	☐
Other (list) _____	☐	☐
9) Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
10) *Women only:*		
A) Are you pregnant or think you may be pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking oral contraceptives?	☐	☐

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7) Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High blood pressure	☐	☐	Heart disease	☐	☐	Chest pains	☐	☐
Heart attack	☐	☐	Cardiac pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic fever	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Swollen ankles	☐	☐	Angina	☐	☐	Hay fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation therapy	☐	☐
Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetes	☐	☐	Joint replacement or implant	☐	☐	Heart trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory problems	☐	☐
AIDS or HIV infection	☐	☐	Sexually transmitted disease	☐	☐	Mitral valve prolapse	☐	☐
Thyroid problem	☐	☐	Stomach troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Date of Last Dental Exam

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	YES	NO
1) Do your gums bleed while brushing or flossing?	☐	☐
2) Are your teeth sensitive to hot or cold liquids or foods?	☐	☐
3) Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
4) Do you feel pain to any of your teeth?	☐	☐
5) Do you have any sores or lumps in or near your mouth?	☐	☐
6) Have you had any head, neck or jaw injuries?	☐	☐
7) Have you ever experienced any of the following jaw problems?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	YES	NO
8) Do you have frequent headaches?	☐	☐
9) Do you clench or grind your teeth?	☐	☐
10) Do you bite your lips or cheeks frequently?	☐	☐
11) Have you ever had any difficult extractions in the past?	☐	☐
12) Have you ever had any prolonged bleeding following extractions?	☐	☐
13) Have you had any orthodontic treatment?	☐	☐
14) Do you wear dentures or partials?	☐	☐
If yes, give placement date _____		
15) Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16) Do you like your smile?	☐	☐

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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian, if minor): X_____

Doctor's Comments

Signature

Date