SOUTH JERSEY
CENTER FOR ADVANCED DENTISTRY

750 Route 73 South, Suite 209 Marlton, NJ 08053 Office (856) 988-7773 * Fax (856) 988-7703 * www.marltondentist.com

LaDerrick Bullock, D.M.D.

NAME: _____ DATE: _____

NICKNAME:_____ DATE OF BIRTH: _____ E-MAIL ADDRESS _____

ADDRESS: _____CITY AND ZIP: _____

PHONE: (_____) _____ CELL PHONE (_____)_____

EMPLOYER:_____ SS#_____

EMPLOYER PHONE: (_____)_____OCCUPATION:_____

SPOUSE:_____OCCUPATION: _____EMPLOYER: _____

DRIVER'S LICENSE #:

WHO REFERRED YOU TO OUR PRACTICE:

INSURANCE INFORMATION

INSURED'S NAME _____INSURED'S DOB _____ / _____ / _____

EMPLOYER _____INS

INSURANCE COMPANY _____GROUP #, _____

INSURANCE CO ADDRESS_____PHONE#_____

IS POLICY CONNECTED WITH YOUR UNION? YES _____NO_____ NAME OF UNION_____LOCAL#

DO YOU HAVE DUAL COVERAGE? YES NO IF YES: PLEASE COMPLETE THE FOLLOWING SECONDARY INSURANCE INFORMATION.

INSURED'S NAME _____ INSURED'S DOB_____ / _____ / _____

EMPLOYER _____ INSURED'S SS#_____

EMPLOYER'S ADDRESS_____

INSURANCE COMPANY _____ GROUP #_____

INSURANCE CO ADDRESS_____ PHONE # _____

IS POLICY CONNECTED WITH YOUR UNION? YES _____ NO _____NAME OF UNION _____ LOCAL#_____

PHYSICIAN'S NAME, ADDRESS AND PHONE NUMBER:

ARE YOU TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION? _____

IF YES, PLEASE LISTAND THE REASON _____

ARE THERE ANY PRESCRIBED MEDICATIONS THAT YOU ARE SUPPOSED TO TAKE BUT ARE NOT TAKING AT THIS TIME?

DO YOU HAVE ANY PHYSICAL OR MENTAL CONDITIONS?

MEDICAL HISTORY

MITROVALVE PROLAPSE, RHEUMATIC FEVER, HEART CONDITION	Y	N
HAVE YOU HAD ANY TYPE OF JOINT SURGERY INCLUDING JOINT REPLACEMENT	Y	N
DIABETES	Y	N
CANCER/CHEMOTHERAPY	Y	N
KIDNEY DISEASE	Y	N
STROKE	Y	N
EPILEPSY	Y	N
HEPATITIS	Y	N
PROLONGED HEALING OR BLEEDING PROBLEMS	Y	N
SINUS PROBLEMS	Y	N
HIGH/LOW BLOOD PRESSURE	Y	N
HEADACHES	Y	N
RESPIRATORY DISEASE OR ASTHMA (allergy or non-allergy)	Y	N
HAVE YOU EVER BEEN TESTED FOR HIV	Y	N
AIDS, ARC, OR POSITIVE ANTIBODY TEST TO HTLV-1 11	Y	N

ALLERGIES: DRUGS _____ FOOD _____ LATEX_____ OTHER
ARE YOU PREGNANT? _____ OB/GYN:

IS THERE ANY ADDITIONAL INFORMATION THAT WOULD HELP US MAKE YOU MORE COMFORTABLE?

_____

ARE YOUR TEETH SENSITIVE TO ANY OF THE FOLLOWING:

HEAT OR COLD	Y	N
SWEETS OR SOUR	Y	N
BITING PRESSURE	Y	N

DO YOU SMOKE OR CHEW TOBACCO? Y N

HAVE YOU HAD TEETH REMOVED?_____ IF YES, WHEN _____

HAVE YOU EVER HAD BRACES? _____IF YES, WHEN _____
HAVE YOU EVER HAD ANY RETAINERS, NIGHTGUARD, OR SPLINTS MADE? Y N

WHEN WAS YOUR LAST DENTAL APPOINTMENT?

HAVE YOU EVER USED ANY TOOTH WHITENING PRODUCTS? TAKE HOME TRAYS IN OFFICE PROCEDURE CATALOG OR TV ORDER _____ OR OVER THE COUNTER PRODUCTS

IF YES, WERE YOU SATISFIED WITH THE RESULTS? Y N COMMENTS _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

I understand my appointment has been reserved exclusively for me. If I do not give the office 48 hours notice (excluding weekends and holidays) I will be charged a fee that is not covered by my dental insurance.

Our office will accept assignment on your insurance. However, you will be responsible for any unpaid balance that your insurance policy does not cover.

Method of payment today will be: Visa/MC, Discover, Amex, Check or Cash?

In case of separation/divorce the parent that signs the medical history form will be responsible for all fees incurred at all visits.

Please note that all responsible collection, legal costs, including but not limited to finance charges required to collect fees due LaDerrick Bullock, D.M.D. will be borne by the undersigned.

Authorization to Release Information

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim Administrator(s), and consulting health care professionals, information concerning health care, advise, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

PATIENT SIGNATURE / DATE_____ INTERVIEWER _____