David I. Ferguson, D.D.S.
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Upper Montclair, NJ 07043-1722
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frontdesk@fergusondental.com

Date _____

Patient's Name _____ Date of Birth _____
Last First M

Address _____
Street City Zip

Phone _____ Cell Phone _____ Work Phone_____

E-Mail Address _____ Occupation_____

How would you prefer to be contacted (please circle)? Phone (home, cell, or work) Email Postcard

Sex: M F ☐ Married ☐Domestic Partnership ☐Single ☐Separated ☐Widowed ☐Divorced

Name of Spouse/Partner _____

Whom may we thank for referring you to our office? _____

Who will be responsible for paying this account? _____

Sex: ☐ Male ☐ Female Date of Birth _____Home Phone _____ Bus. Phone _____

Address

_____
Street City Zip

Dental History

Reason for visit _____

Are you having pain or discomfort at this time? _____

When was your last dental visit? _____ Former Dentist/Periodontist _____

Have you ever had any problem associated with previous dental treatment? ☐Yes ☐No

If yes, please explain _____

Is there anything you don't like about your smile? ☐Yes ☐No

If yes, please explain _____

Do you have dental implants? ☐Yes ☐No

How often do you brush your teeth? ____/ per day

What kind of toothbrush do you use? ☐ Extra Soft ☐ Soft ☐ Medium ☐ Hard ☐ Manual ☐ Electric

How often do you floss your teeth? _____

Do you have any tooth sensitivity? ☐Yes ☐No

If yes, please explain _____

Do you believe your gums are healthy? ☐Yes ☐No

If no, please explain _____

Have you ever been told you have had periodontal disease? ☐Yes ☐No

Do you have any of the following:

☐ Neck Pain ☐ Jaw Pain ☐ Jaw noises (Clicking, Popping, Grinding, etc.)

If so, please explain _____

Have you ever been told you have TMJ disorder? ☐Yes ☐No

Do you usually have many cavities? ☐Yes ☐No

Do you often lose or break fillings? ☐Yes ☐No

Do you gag easily? ☐Yes ☐No

Do you have any growths or sore spots in your mouth? ☐Yes ☐No

Please add anything you feel is important! _____

PLEASE TURN TO THE OTHER SIDE

Medical Health History

1. Physician's Name _____ City _____ Phone _____
2. Have you been under the care of a physician or been hospitalized during the past two years? _____ If yes, please explain

   _____
3. List any medications you are presently taking

   _____
4. Are you taking any of the following medications? ☐Aspirin ☐ Steroids ☐ Cortisone ☐ Blood Thinners
   - ☐ Fosamax, Boniva, Actenol or other Bisphosphonate
5. List any medications or substances you have had an adverse or allergic reaction to _____

   _____

   Have you ever had an allergic reaction to latex? ☐ Yes ☐ No
6. **Women:** Are you taking Birth Control Pills? ☐ Yes ☐ No

   Are you now pregnant? ☐ Yes ☐ No Due Date_____ Nursing? ☐ Yes ☐ No
7. Indicate which of the following you have had or have at present:

☐ Heart Disease or Attack	☐ Diabetes	☐ Cancer _____	☐ Hemophilia
☐ Angina Pectoris	☐ Kidney Trouble	☐ Radiation Therapy	☐ Bruise Easily/ Excessive Bleeding
☐ High Blood Pressure	☐ Liver Disease	☐ Chemotherapy	☐ Epilepsy/ Seizures
☐ Heart Murmur	☐ Hepatitis	☐ Arthritis	☐ Fainting or Dizzy Spells
☐ Mitral Valve Prolapse	☐A ☐B ☐C ☐D ☐E	☐ Osteoperosis/Osteopenia	☐ Nervousness
☐ Rheumatic Fever	☐ Tuberculosis	☐ Joint Replacement	☐ Psychiatric Treatment
☐ Congenital Heart Defect	☐ Asthma	☐ AIDS	☐ Cosmetic Surgery
☐ Medicated Coronary Stent	☐ Sinus Trouble	☐ HIV+	☐ Drug Addiction
☐ Artificial Heart Valve	☐ Seasonal Allergies	☐ Sexually Transmitted Disease	☐ Alcohol Use _____/ Day
☐ Heart Pacemaker	☐ Emphysema	☐ Cold Sores/ Fever Blisters	☐ Tobacco Use _____/ Day
☐ Heart Surgery	☐ Thyroid Disease	☐ Ulcers/Stomach Problems	
☐ Stroke	☐ Glaucoma	☐ Sickle Cell Anemia	

8. Do you have any diseases, conditions, or problems not listed?
9. In case of emergency please contact?
   Name: _____Phone Number: _____

Insurance

We feel that it is in the best interest of our patients to not participate with any insurance plan. However, we are happy to maximize your benefits and reimbursement for all services. After each visit you will receive a superbill to submit to your insurance company for direct reimbursement, and we will assist you in this process.

Consent

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. **If I ever have any change in my health, I will inform the doctors at the next appointment without fail.** The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of the Patient) _____ and further authorize and consent the Doctor choose and employ such assistance as deemed fit. I understand that responsibility for payment for Dental Services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient _____ Date _____

Parent or Responsible Party _____Relationship to Patient _____