FREDA & SURIANO, ORTHODONTICS, P.A.

NJ State Specialty License Numbers- #3386, #3388
1310 Broad Street - Bloomfield - NJ - **(973) 748-2248**
191 Main Street - Chester- NJ - **(908) 879-0987**
122 Morristown Road- Bernardsville- NJ - **(908) 766-1252**
2A Doctors Park Seber Road - Hackettstown- NJ - **(908) 852-1252**

PATIENT HISTORY

Date :_____
Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip Code:_____
Home Phone #: (_____)_____-_____ Birthday: _____
Sex: Male_____ Female_____ How were you referred to this office?_____
Emergency contact name and phone number: _____

RESPONSIBLE PARTY FOR PAYMENT

Party responsible for payment: _____
Relation to patient: _____ Responsible party's birthday_____
Responsible party's SS # ____-____-_____ Drivers License Number: _____
Address (*if different from above*): _____
Phone # (*if different from above*): (____)_____-_____ Buss.Phone #: (_____)_____-_____
Cell Phone: _____ Email Address: _____
Business Name: _____
Business Address: _____
Occupation: _____

INSURANCE INFORMATION - (*Orthodontic Insurance Only)*

Primary Insurance:

Subscriber's Name: _____ S.S. #:_____
Address _____ Birthday _____
Insurance Co. Name: _____
Group #: _____ Ins. Co. Phone #: (_____)_____-_____
Address: (*where to submit claims* **-very important!**) _____
_____
Employer: _____ Employer's Phone #: (_____)_____-_____
Employer's Address: _____

Secondary Insurance:

Subscriber's Name: _____ S.S. #:_____
Address _____ Birthday _____
Insurance Co. Name: _____
Group #: _____ Ins. Co. Phone #: (_____)_____-_____
Address: (*where to submit claims* **-very important!**) _____
_____
Employer: _____ Employer's Phone #: (_____)_____-_____
Employer's Address: _____

MEDICAL HISTORY

General Health (check one): [] Excellent [] Good [] Fair [] Poor

Physician's Name: _____ Address:_____

Date of last Physical exam: _____

Please indicate any of the following items that pertain to the patient:

[] Kidney disease	[] Venereal Disease	[] Diabetes
[] Liver Disease	[] Hepatitis	[] Thyroid
[] Heart related concerns	[] Rheumatic Fever	[] Anemia
[] Tuberculosis	[] Speech/Hearing problems	[] Asthma
[] Neurological Disorders	[] Epilepsy	[] AIDS or HIV+
[] Bleeding Disorders	[] ADD or ADHA	[] Psychological

Other: _____

Has the patient been hospitalized over the past two years requiring overnight stay? [] YES [] NO
If yes, please specify: _____

Is the patient taking any medications at this time?: [] YES [] NO
If yes, please specify: _____

Does the patient have any allergies to medication?: [] YES [] NO
If yes, please specify: _____

Brothers and/or Sisters: Name: _____ Birthday: _____
Name: _____ Birthday: _____
Name: _____ Birthday: _____

DENTAL HISTORY

Dentist's Name: _____
Dentist's Address: _____
Date of last dental exam: _____
Please indicate any specify dental concerns you may have: _____
_____

I verify the accuracy of the information provided above.

_____ _____

Patient/ Parent/ Guardian Signature **Date**