

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) 766-2555

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