South Jersey Center for Dental Medicine
JOSEPH A. SANDBERG D.M.D.

PATIENT INFORMATION

First Name _____ MI___ Last Name_____ Birthday _____
Social Security Number _____ Address _____ City _____
State _____ Zip Code _____ E-mail _____ Cell Phone _____
Home Phone _____
Circle One: Minor Single Married Divorced Widowed Separated
Emergency Contact Name _____ Emergency Contact Phone Number _____

EMPLOYER INFORMATION

Employer _____ Employer Address _____
City _____ State _____ Zip Code _____ Phone Number _____

INSURANCE INFORMATION

Primary Insurance Company_____ Group Number _____ ID Number _____
Please complete below if subscriber is not you:
Subscriber's Full Name _____ Employer _____ Birthday _____
Social Security Number _____ Relationship To Patient: Spouse Parent Other_____
Secondary:
Insurance Company_____ Group Number _____ ID Number _____
Please Complete Below If Subscriber Is Not You:
Subscriber's Full Name _____ Employer _____ Birthday _____
Social Security Number _____ Relationship To Patient: Spouse Parent Other_____

MEDICAL HISTORY

Physician: _____ Office Phone Number _____ Date Of Last Exam: _____
1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s), including non-prescription medicine? Yes No
If yes, please list medication(s):_____
_____.
4. Do you smoke? If yes: What do you smoke and for how long have you been smoking?_____
5. Do you drink alcohol? If yes: How frequently?_____
6. Do you use any other drugs? If so please specify: _____
7. Have you tested positive for COVID-19? Yes No
8. Circle any allergies: Local Anesthetic Penicillin Or Other Antibiotics Latex Aspirin Nickel None
Other:_____
9. Women Only: Are you pregnant or think you may be pregnant? Yes No
10. Are you nursing? Yes No
11. Are you taking birth control pills? Yes No
12. Address of preferred pharmacy: _____

13. Circle any prior or current conditions:

High Blood Pressure	Heart Attack	Rheumatic Fever	Swollen Ankles	Seizures
Asthma	Liver Disease	Epilepsy/Convulsions	Leukemia	Diabetes
Kidney Disease	AIDS or HIV Infection	Thyroid Problem	Heart Disease	Ulcers
Heart Murmur	Angina	Frequently Tired	Anemia	Emphysema
Cancer	Arthritis	Joint Replacement	Stomach Problems	Hepatitis/Jaundice
Chest pains	Easily Winded	Stroke	Hay fever/Allergies	Tuberculosis
Radiation Therapy	Glaucoma	Recent Weight Loss	Low Blood Pressure/ Fainting	Cardiac Pacemaker/ Valve Replacement
Respiratory Problems	Sexually Transmitted Disease			

Other:_____

_____

PATIENT DENTAL HISTORY

1. Teeth sensitive to: Cold Hot Sweet Sour No sensitivity
2. Circle any of the following problems pertaining to your jaw:
   Clicking Pain Difficulty Opening/Closing Difficulty Chewing None
3. Do your gums bleed while brushing or flossing?
4. Do you have any dental pain?
5. Do you have any sores or lumps in or near your mouth?
6. Do you have any history of head, neck or jaw injuries?
7. Do you have frequent headaches?
8. Do you clench or grind your teeth?
9. Have you had prolonged bleeding after an extraction?
10. Have you had orthodontic treatment done?
11. I think the present state of my teeth is: Very Healthy Some Disease/Decay In Poor State
12. Improving the health of my mouth is: High Priority Medium Priority Low Priority
13. Improving the appearance of my smile is: High Priority Medium Priority Low Priority
14. In the past, I have gone to the dentist: Regularly Occasionally For Emergency Care Only

SIGNATURE

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.

X _____ _____

Signature Date