RETHINK
DENTAL HEALTH

In order to provide the best possible care, it is important that we get to know your history and concerns. Although filling out forms is tedious, we ask that you answer these questions to the best of your knowledge. Thank you.

Your Information:

Name:____ Preferred Phone: ________________________

Address: _____________________________________ Alternative Phone:_______________________

City, State, Zip: _________________________________ Email Address: _________________________

Is there anyone we may thank for referring you to us: _____________________________________

Birth date: __________________ Social security number_______________________

Emergency contact: _________________________ Emergency contact phone:_____________________

Work location: ____

Preferred pharmacy name and location: ____

General Health Information

My General Health (circle one or insert number): 1 2 3 4 5 6 7 8 9 10 (10=Best)______________

Last Routine Physical: _____________________Type of Physician(MD, OD, ND, etc.):________________________

Physician's Name: ________________________ Physician's specialty: ____________________________________

In addition to the above physician, I see the following healthcare providers:

Physician: ____________________________ Reason:____

Physician: ____________________________ Reason:____

The statement that best describes me:

_______I am healthy and seek health oriented, whole body minded practitioners.
_______I am healthy but have had some dental issues in the past which I am concerned about.
_______I have health issues which I believe affect my dental health.
_______I have dental issues which I believe are affecting my overall health.
_______I have the same dental issues repeatedly without true resolution.
_______I have a health challenge and am seeking removal of anything standing in my way of healing.
_______I have or have had an occupation which exposes me to toxic chemicals

I have been diagnosed with a chronic health issue:

_______Lyme disease
_______Heavy metal toxicity
_______Multiple sclerosis
_______Hashimoto's or thyroid disorder
_______Electromagnetic sensitivity
______Other:

_______Co-infections of Lyme
_______Chronic fatigue syndrome
_______Chronic fungal infections
_______Environmental sensitivity
_______Lymphatic edema

201 S. Main St., suite 3N
Lambertville, NJ 08530
Phone:609.460.4574

281 Witherspoon St., suite 225
Princeton, NJ 08540
Phone: 609.228.0033

info@rethinkdentalhealth.com

RETHINK DENTAL HEALTH

Women's Health Information:

_______Pregnant, may be pregnant
_______Planning a pregnancy/nursing
_______I care for small children
_______I am using hormone replacement therapy
_______Not pregnant
_______I have small children
_______Using hormones to prevent pregnancy

Check any of those apply:

_______High blood pressure
_______Anemia
_______Abnormal bleeding
_______Blood disease
_______Heart disease
______ Mitral valve prolapse
_______Heart Murmur
_______Respiratory disease
_______Asthma
_______COPD
_______ Alzheimer's
_______Chronic sinusitis
_______Emphysema
_______Diabetes
_______Depression
_______Psychosis
_______Neurological disorder
_______Family history of
_______Epilepsy
_______Unintentional weight gain
_______Rheumatic Fever
_______Immune disorder
_______Thyroid disease
_______Kidney Disease
_______Liver disease
_______Hepatitis
_______HIV/AIDS
_______Venereal disease
_______Cancer
_______Radiation
_______Chemotherapy
_______Surgery
_______Scars
_______Hospitalization

Supplement and Drug History: (If many, please bring a complete listing to your appointment)

Current medications ____

____

Current supplements ____

I am allergic to or do not tolerate these medications (include dental): ______________________

My reaction was: ____

Latex allergy____________________Sensitivity to various materials______________________

Diet and Lifestyle:

Occupation: ______________________________

Regular exercise goal actual _______Actual _______

I consume _______ alcoholic servings per _________

My weight is stable ______________BMI _________

Fish I enjoy __________________per week _______

My diet includes meat ______________________

I have the following major stressors in my life right now:

Tobacco use: _____Yes _____No. Type: _________

I eat about _________ GOOD meals a day.

I drink about _______glasses of water a day.

Type of salt I prefer __________________

Type of sweetener I prefer ______________

I have at least 1 bowel movement a day ______

I sweat well when exercising_______________

____

201 S. Main St., suite 3N
Lambertville, NJ 08530
Phone:609.460.4574

281 Witherspoon St., suite 225
Princeton, NJ 08540
Phone: 609.228.0033

info@rethinkdentalhealth.com

RETHINK DENTAL HEALTH

DENTAL Health Information

My Dental Health (circle one or insert number): 1 2 3 4 5 6 7 8 9 10 (10=Best)

Date of last dental exam: _______________ X-rays taken? _____Yes _____No

Please understand that the Dr. may find past x-rays helpful but not find them useful for current diagnosis and may request others.

Suggested treatment at that time:

____

I ____ did follow up ____________did not follow up on that treatment.

I am anxious before dental appointments _________________________________

Dental Medical History:

Antibiotics given prior to dental procedures: ___________________ Reason:____________________________

Negative experience with dental anesthetics: __________________ Reaction was:______________________

I have taken the following relaxing drugs prior to dental appointments: ________________________________

_______I have had my mercury fillings removed _______I under went detoxification for mercury

_______I had orthodontic treatment _______My teeth are sensitive

_______I have been told I have TMD _______I wear a night guard

_______I have had jaw surgery _______I had root canal treatment

_______I sometimes get a metallic taste in my mouth _______I have been checked for oral cancer

As a courtesy to our patients we will submit your insurance claims as soon as we have the complete information requested below.

Insurance Information:

Name of Policy Holder: ____________________________________ DOB: ______________

Name of the Insurance Company: _________________________________

Insurance ID _____________________________

Group # : ________________________________

Insurance Company's Address ____

Insured's Employer: ____

Secondary Insurance:

Name of Policy Holder: ____________________________________ DOB: ______________

Name of the Insurance Company: _________________________________

Insurance ID _____________________________

Group # : ________________________________

Insurance Company's Address ____

Insured's Employer: ____

I understand the information above is necessary in order to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or medications.

Patient Name (please print)________________________ Patient Signature _____________________

Date ____________

Please call or email us with any questions. We look forward to meeting you.

201 S. Main St., suite 3N
Lambertville, NJ 08530
Phone:609.460.4574

281 Witherspoon St., suite 225
Princeton, NJ 08540
Phone: 609.228.0033

info@rethinkdentalhealth.com