Welcome

A Beautiful Smile Dentistry
1315 Anderson Ave, Unit A
Fort Lee NJ 07024
(201) 224-4400
Dr. David Jin DDS

Welcome: Patient Info

Thank you for choosing us to be part of our extended dental health family. Please fill out this form as completely as you can. (Please print)

PATIENT INFORMATION:

Name_____ ❑Dr. ❑Mr. ❑Mrs. ❑Ms. ❑Other _____
First MI Last

Home Address_____ Occupation_____ ❑Male ❑Female

City_____ State_____ Zip_____ Cell # (___)_____ ❑Prefer to receive text

Employer_____ Work# (___)_____ Ext_____

Are you: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed Home# (___)_____ ❑Prefer to call home #

DOB ___/___/___ SSN#_____ *e*Mail_____

Is patient a full time student? ❑ NO ❑YES, Name of School_____

by giving us email you are authorizing us to contact you via email

Spouse's Name_____
First MI Last (If different)

Spouse's occupation_____ Work# (___)_____ Ext_____

RESPONSIBLE PARTY: (if different than patient)

Name_____
First MI Last

Address_____

City_____ State_____ Zip_____

Home # (___)_____

Work# (___)_____

DOB ___/___/___

SSN#_____

Relationship_____

About Dr. David Jin LCDR USNR (Sep):
US Navy General Surgical Residency: National Naval Medical Center
Doctor of Dental Surgery: New York University, School of Dentistry
Certified CEREC Trainer and Speaker
Certified BLS/ACLS Trainer and Speaker for HUMC
Academy of General Dentistry Continue Education Provider/Speaker
Member:
American Dental Association
Academy of General Dentistry
AACD (Cosmetic Dentistry)
AAID (Implant Dentistry) Fellow
AASM (Sleep Medicine)
AADSM (Dental Sleep Medicine)

Your Preferences
*How do you wish to be address by our team members?*_____
*Whom may we thank for referring you?*_____
Do you prefer your appointment confirmation reminder by: ❑ *Phone* ❑*eMail* ❑*Text*
please note: eMail and Text services is not available at this moment

INSURANCE INFORMATION:

MEDICAL INSURANCE:

Subscriber's Name_____ Relationship to patient_____

Subscriber's DOB___/___/___ Subscriber's SSN#_____ Employer_____

Insurance Company_____ Policy #_____ Group #_____

DENTAL INSURANCE:

Subscriber's Name_____ Relationship to patient_____

Subscriber's Address_____ City_____ State_____ Zip_____

Subscriber's DOB___/___/___ Subscriber's SSN#_____ Employer_____

Insurance Company_____ Policy #_____ Group #_____ Effective Date___/___/___

Do you have additional Dental Insurance? ❑*No* ❑*Yes, if yes, please complete the following:*

*Subscriber's Name*_____ *Relationship to patient*_____

*Subscriber's Address*_____ *City*_____ *State*_____ *Zip*_____

*Subscriber's DOB*___/___/___ *Subscriber's SSN#*_____ *Employer*_____

*Insurance Company*_____ *Policy #*_____ *Group #*_____ *Effective Date*___/___/___

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Since 2003: Our office is one of the most advanced and experienced CAD/CAM practice in US. We use 3D x-Ray to help our patient see and understand their underlying health and potential hazards. We are dedicated in helping you to enjoy good oral health for life. Dr. Jin

Next>>

Please print and circle the answer below, you can then scan and email to: records@absDentistry.com or fax to: (201)224-4418

Medical History

While Dental office personnel primarily focus on and treating area in and around your mouth, your mouth is a vital part of your body. Health conditions or problems that you may have or had, or medications that you may be taking, could have important inter-relationships with the treatment you will receive. Please answer the following to the best of your knowledge. If anything requires clarification, please ask any of our team members for help. Thank you.

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Latex powder	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metals (What?_____)	Y	N
Sulpha	Y	N
Other:_____	Y	N

List any other known allergies:

_____

_____

_____

Endocrine

Diabetes	Y	N
Thyroid Problems	Y	N
Hormonal Change/Therapy	Y	N

Eyes, Ears, Nose and Throat

Changes in Vision	Y	N
Glaucoma	Y	N
Meds?_____		
Changes in Hearing	Y	N
Ear Pain	Y	N
Tinnitus (ringing in ear)	Y	N
Dysphagia (Difficulty in swallowing)	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Tonsillectomy	Y	N
Sinus Problems	Y	N

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Requires Prophylactic Antibiotic?	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Other heart issues:

_____

_____

General

Current Weight: _____Lbs		
Height: _____ft _____in		
Recent Weight Chages	Y	N
Fatigue/Tired Easily	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Liver Problems	Y	N
Rheumatic Fever	Y	N
Hip/Knee Replacement	Y	N
Cancer	Y	N
Where?_____		
Radiation Treatment	Y	N
Chemo Therapy	Y	N
Recent Trauma or injury	Y	N
Where?_____		

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Ulcers	Y	N
Soft or Special Diet	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney Disease	Y	N

Hematological

Bleeding Issues	Y	N
Hepatitis	Y	N

Musculoskeletal

Bisphosphonate Therapy	Y	N
What?_____		
Back pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neruological

Alzheimer's Disease	Y	N
Dizziness/Fainting Spells	Y	N
Memory Loss	Y	N
Multiple Sclerosis(MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Are you required to take any medication before your dental procedure? Y N

What?_____

Oral

Bleeding Gums	Y	N
Periodontal Disease	Y	N
Dry Mouth	Y	N
Jaw Problem (TMJ)	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Chewing	Y	N
Difficulty Swallowing	Y	N
History of Ortho/Invisalign	Y	N
Teeth Clenching/Grinding	Y	N
Tooth/Teeth Pain	Y	N
Do you wear removable appliances? (Removable Teeth?)	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Excessive Stress	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Congestion/Breathing Problems	Y	N
Chest Pressure	Y	N
Dyspnea (Shortness of breath)	Y	N
Emphysema	Y	N
Pneumonia	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Has anyone told you that you Snore?	Y	N
Do you use a CPAP?	Y	N

How often?_____

Social History

Do you smoke? _____packs/day	Y	N
Smokeless tobacco?	Y	N
Do you use recreational drugs	Y	N
Drink Alcoholic beverages?	Y	N

_____Drinks per day/week/month

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Medical History and Consent

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List any medications you are taking:

	Medication	Dosage/Freq	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

Date(Year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not list above or on previous page:

Primary Care Physician's Name:_____ Phone #:_____

Are you under the care of other physicians? If so, please list

Physician Name: Phone #: Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes A Beautiful Smile Dentistry, LLC, its associated doctors and team members to take radiographs, study models, photographs, and or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental and related health condition and needs. I authorize A Beautiful Smile Dentistry, LLC, its associated doctors and team members to perform any and all forms of treatment, medication, and therapy that may be necessary. I understand that the use of local anesthetic agents and other medications, fillings, materials embody certain risk and consent to their use as deemed appropriate by the treating doctor. To the best of my knowledge, the questions on this form have been answered as accurately as possible. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform this health care facility of any change in medical health or status.

FINANCIAL CONSENT: I understand that the responsibility for payment of services provided in this office for myself and those I have claimed financially responsible (dependents) is mine. Payments are due and payable in full for the services rendered. I understand that I am responsible for any and all of the portion of fees for services rendered that is not covered by my medical/dental insurance (if any). I further consent to and agree to pay a 2% late payment fee per month (24% annually) for any amount outstanding for 30 days or more. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize A Beautiful Smile Dentistry, LLC and its staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (Adult):

Name of Patient:_____ _____ _____

Signature of patient Date

Consent (for a minor child):

Name of Parent/Guardian:_____ _____ _____

Signature of parent/Guardian Date

Notice of Privacy Practice (below)

Patient privacy is important to our office. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow the release of pertinent medical records to my insurance company (if applicable) and my other medical/dental healthcare providers.

Please print the answer above, you can then scan and email to: records@absDentistry.com or fax to: (201)224-4418