

New Patient Information

Please fill out form completely. Thank You

Date	/	/
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Michael Messing DDS MPH
 7 Short Hills Avenue
 Short Hills, NJ 07078
 973-921 -0771

PATIENT INFORMATION			
Patient's Name		Phone Number	
		Home	Work Cell
Street Address		City	State Zip
Age	Date of Birth / /	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Who may we thank for referring you?
Family Physician		Family Dentist	
In Case of Emergency, Who Should be Notified?		Relationship/Phone	

PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:

Name _____	Employer Name _____
Address _____	Employer Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____ SS# _____	Work Phone _____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insurance _____	Name of Insured _____
Address _____	Insured's Date of Birth _____
City _____ State _____ Zip _____	Insured's Employer _____
	Policy/ID# _____ Effective Date _____

Signature of Patient,
 Parent, or Guardian _____

Date _____

Signature of Insured _____

Date _____

MEDICAL HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Adenoids
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Autoimmune Disorders
<input type="checkbox"/> Bleeding Easily
<input type="checkbox"/> Blood Pressure- High
<input type="checkbox"/> Blood Pressure- Low
<input type="checkbox"/> Bruising Easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Cold Hands/Feet
<input type="checkbox"/> Current Pregnancy
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Difficulty Concentrating
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Fluid Retention
<input type="checkbox"/> Frequent Cough
<input type="checkbox"/> Frequent Illnesses
<input type="checkbox"/> Frequent Stressful Situations
<input type="checkbox"/> General Anesthesia
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gout
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Other Medical/Dental History _____ | <input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Heart Disorder
<input type="checkbox"/> Heart Pacemaker
<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Heart Valve Replacement
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Immune System Disorder
<input type="checkbox"/> Injury to Face
<input type="checkbox"/> Injury to Mouth
<input type="checkbox"/> Injury to Neck
<input type="checkbox"/> Injury to Teeth
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Intestinal Disorders
<input type="checkbox"/> Jaw Joint Surgery
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Meniere's Disease
<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Muscle Aches
<input type="checkbox"/> Muscle Shaking (Tremors)
<input type="checkbox"/> Muscle Spasms or Cramps
<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Needing Extra Pillows to Help Breathing at Night
<input type="checkbox"/> Nervous System Irritability
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Neuralgia | <input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Prior Orthodontic Treatment
<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Slow-Healing Sores
<input type="checkbox"/> Snoring
<input type="checkbox"/> Speech Difficulties
<input type="checkbox"/> Stroke
<input type="checkbox"/> Swollen, Stiff or Painful Joints
Tendency For:
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Sore Throats
<input type="checkbox"/> Tired Muscles
<input type="checkbox"/> Tonsils Removed
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors
<input type="checkbox"/> Urinary Disorders
<input type="checkbox"/> Wisdom Teeth (3rd Molar) Extraction
<input type="checkbox"/> Yeast Infections |
|--|--|--|

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION

- | | | |
|--|---|---|
| <input type="checkbox"/> Antibiotics
<input type="checkbox"/> Aspirin
<input type="checkbox"/> Barbiturates
<input type="checkbox"/> Codeine
<input type="checkbox"/> Iodine | <input type="checkbox"/> Latex
<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Metals
<input type="checkbox"/> Penicillian
<input type="checkbox"/> Other Allergans _____ | <input type="checkbox"/> Plastic
<input type="checkbox"/> Sedatives
<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Sulfa Drugs |
|--|---|---|

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

- | | | |
|---|---|---|
| <input type="checkbox"/> Antibiotics
<input type="checkbox"/> Anticoagulants
<input type="checkbox"/> Barbiturates
<input type="checkbox"/> Blood Thinners
<input type="checkbox"/> Codeine
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Cortisone
<input type="checkbox"/> Diet Pills
<input type="checkbox"/> Heart Medication
<input type="checkbox"/> Insulin
<input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Nerve Pills
<input type="checkbox"/> Pain Medication
<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Tranquilizers |
|---|---|---|

WOMEN: Are you pregnant?

Yes No

If yes, how long?