425 ESSEX STREET
MILLBURN, NJ 07041

PHONE: 973 535 4300
FAX: 973 535 4308

Arthur Greyf DDS, FICOI
Implant, Cosmetic & Laser Dentistry

WELCOME TO THE CENTER OF HAPPY SMILES!

Patient Information

Welcome and thank you for choosing DNA Dental for your dental needs. Please complete this form in PRINT, if you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

First Name ______________________________ Middle Initial ____________________

Last Name_______________________________ Date of Birth ____________________

SS/HIC/Patient ID #________________________

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Minor

Address ____________________________________ City______________________

State______ Zip ________ Sex: ☐ Female ☐ Male

Home Phone _____________________ Cell Phone ________________________

Work Phone ______________________

Do you prefer to receive calls at: ☐ Home ☐ Cell ☐ Work ☐ No Preference

Email ____

We kindly request you to provide us with your email address. We respect your time, privacy and personal information; therefore, we would like to email you your appointment reminders and notifications. For your convenience we also offer to set up an appointment by emailing us at frontdesk@dnadental.com or officemanager@dnadental.com. If you choose to email us requesting an appointment please specifying the most convenient time for us to give you a call to schedule your next appointment. We would be happy to accommodate you and find the time that fits your busy schedule.

☐ - Yes, I would like to receive my appointment reminders, notifications and updates via email.

☐ - No, I would like to receive my appointment reminders, notifications and updates by (please let us know how would you like to be contacted) ____________________________

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Occupation ______________________ Patient Employer/School ______________________

Spouse's or parent's name ______________________ Phone # ______________________

Person to contact in case of emergency ______________________ Phone # ______________________

How did you hear about us? ☐ Referred by a Dr. ______________________

☐ Referred by a patient / friend ______________________

☐ Other: ☐ Valpak
☐ Our Website
☐ Other Websites: ______________________

Medical History

Attending Physician ______________________ Date of the last visit __________

Please list all medications you are currently taking:

____

____

Please let us know about your allergies (food, medications and etc.):

____

Please check (☑) if you have had any of the following:

☐ AIDS
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back problems
☐ Bleeding Abnormality
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Swelling of Feet or Ankles
☐ Fainting
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Heart Murmur
☐ Heart Problems
Please Describe __________
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ Scarlet Fever
☐ HIV Positive
☐ Jaw Pain
☐ Epilepsy
☐ Liver Disease
☐ Tobacco Habit
☐ Headaches
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ High Blood Pressure
☐ Skin Rash
☐ Shortness of Breath
☐ Stroke
☐ Kidney Disease
☐ Thyroid Problems
☐ Glaucoma
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

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Have you ever taken any of these medications?

Diet Medications:	☐ Dexfenfluramine	☐ Fen-Phen	☐ Pondimin	☐ Redux
Blood Thinners:	☐ Coumadin	☐ Warfarin		
Other:	☐ Levoxyl	☐ Synthroid		

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________
Name of Insurance Company(ies)
and assign directly to Dr. A. Greyf all insurance benefits, if any, otherwise payable to me for services rendered. I understand that am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient