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Mr. ___ Mrs. ___ Ms. ___ Dr. ___ Date: ___/___/___

NAME: _____

Date of Birth ___/___/___ Patients SS# ___-___-___

Address _____ Street _____ Town _____ Zip _____

Home # _____ Cell# _____ Work# _____

E-Mail Address _____

Name of your General Dentist _____

Person Financially Responsible for Treatment _____

In the unlikely event of an emergency, is there someone we should contact?

Name: _____ Phone# _____ Relationship _____

Primary Dental Coverage If you have Secondary Dental Coverage

Name of Primary Insured Person _____ Name of Secondary Insured Person _____

Date of Birth ___/___/___ Date of Birth ___/___/___

Employer _____ Employer _____

Insurance Carrier _____ Insurance Carrier _____

Policy # _____ Policy # _____

Group # _____ Group # _____

SS# or ID# _____ SS# or ID# _____

DATE OF LAST PHYSICAL EXAMINATION _____

WHAT IS YOUR PRESENT HEALTH STATUS _____

DO YOU HAVE, OR HAVE YOU EVER HAD:

AIDS _____ ANEMIA _____ ASTHMA _____ CANCER _____

DIABETES _____ EPILEPSY _____ GLAUCOMA _____ HEPATITIS _____

(JAUNDICE) _____ KIDNEY PROBLEMS _____

RHEUMATIC FEVER _____ THYROID PROBLEMS _____ ULCERS _____

ABNORMAL BLEEDING FROM A CUT _____ LATEX ALLERGIES _____

ARTIFICIAL JOINT REPLACEMENT? _____

DO YOU NEED TO PREMEDICATE? _____

ARE YOU TAKING ANY BIPHOSPHONATES? _____

(i.e. Fosomax, Boniva, Aredia, Zometa, etc)? _____

ALLERGIES: PENICILLIN, OR ANY OTHER ANTIBIOTICS OR DRUGS, OR LOCAL ANESTHETIC (NOVACAINE), LATEX

ABNORMAL HEART CONDITION _____ PACEMAKER _____

ARTIFICIAL VALVES _____ HEART MURMUR _____

MITRAL VALVE PROLAPSE _____ DO YOU NEED TO PRE MEDICATE? _____

ANY PROBLEMS WITH BLOOD PRESSURE? HIGH _____ LOW _____

ARE YOU PREGNANT OR NURSING? _____

ARE YOU TAKING ANY MEDICATIONS? _____ IF SO WHAT? _____

ANY OTHER INFORMATION WE MAY NEED TO KNOW? _____

NAME OF MEDICAL DOCTOR: _____ PHONE# _____

PHARMACY: _____ PHONE # _____

PATIENT'S SIGNATURE: _____

REVIEWED BY DR: _____ DATE: _____

For office use only:

Updated: _____ Patient's Initials _____ Updated: _____ Patient's Initials _____