MARC P. GIMBEL, D.M.D.,L.L.C.
Diplomate, American Board of Endodontics
Practice Limited to Endodontics
CRAIG BERRY, D.M.D., *Diplomate, American Board of Endodontics*
RENA KREITMAN D.M.D.

150 River Road, Suite K-3, Montville, N.J. 07045
973-335-8046

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

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_____

ARTIFICIAL JOINT REPLACEMENT?_____
DO YOU NEED TO PREMEDICATE?_____

ARE YOU TAKING ANY BIPHOSPHONATES?_____
(i.e. Fasomax, Boniva, Aredia, Zometa, etc)?

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

ABNORMAL HEART CONDITION_____PACEMAKER_____

ARTIFICAL 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_____