DR. LLOYD KITCHIN □ 40 Main Street □ Succasunna □ NJ □ 973-584-2533

NEW PATIENT INFORMATION

Today's Date: _____Whom may we thank for referring you? _____

Patient Name: _____ DOB _____ Age: _____
Last First MI (Preferred Name) mm/dd/yyyy

Billing Address: _____
Street Apt/Ste City State Zip Code

Phone (Hm) _____ (Wk) _____ (Ext)_____ (Cell) _____ Gender (Circle) M / F

E Mail:_____ Marital Status: _____ SS # _____

If patient is a minor, Parent/Guardian Name: _____ Relationship to Patient: _____

Insurance Policy Holder's Name: _____ SS# _____ DOB _____

Insurance Policy Holder's Address _____
Street Apt/Ste City State Zip Code

Patient Employer/School _____ Occupation _____ Phone _____

Emergency Contact Name/Relationship/Phone #:_____(____)_____

MEDICAL HISTORY

Do you have or have you ever had any of the following? Please check those that apply:

□ AIDS/HIV Positive
□ Anemia
□ Angina
□ Arthritis/Rheumatism
□ Artificial Heart Valves
□ Artificial Joints
□ Artificial Prosthesis
□ Asthma
□ Back Problems
□ Blood Disorder
□ Cancer; Type _____
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Congenital Heart Lesion
□ Cortisone Treatments
□ Cold Sores
□ Cough Persistant/Bloody
□ Diabetes
□ Drug/alcohol dependency
□ Emphysema/COPD
□ Epilepsy
□ Fainting/Seizures
□ Glaucoma
□ Headaches
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Hepatitis Type: _____
□ High Blood Pressure
□ Jaundice
□ Jaw Pain/Problems
□ Kidney Disease
□ Leukemia
□ Liver Disease
□ Mitral Valve Prolapse
□ Migraines
□ Nervous Disorders
□ Neurological Disorders
□ Pacemaker
□ Psychiatric Care
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Sickle Cell Disease
□ Sinus Problems
□ Special Diet
TYPE _____
□ Stroke
□ Swelling—ankles/feet
□ Thyroid Condition
□ Tonsillitis
□ Tuberculosis
□ Tumor/Growth-head/neck
□ Ulcers
□ Venereal Disease
□ Weight loss—Unexplained

List any other medical conditions you feel the doctor should be aware of: _____

If a female: Are you currently taking oral contraceptives? □ Yes □ No Are you pregnant □ Yes □ No Due Date _____

Please list all medications you are currently taking: _____

Pharmacy Name:_____ Telephone Number:_____ Please list any allergies you are aware of: _____Have you ever had an allergic reaction to: Aspirin_____ Barbiturates (sleeping pills)_____ Codeine_____ Iodine_____ Latex_____ Local anesthetic_____ Penicillin_____ Sulfa Drugs_____Other:_____

Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain: _____

Have you ever had or have abnormal bleeding with extractions/surgery? □ Yes □ No

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No If yes, please explain _____

Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. I understand that providing incorrect or incomplete information can be dangerous to the health of the patient. If there are any changes in health, I will inform the dental staff and doctors at the earliest opportunity.

Signature of patient, parent or guardian _____ Date _____