

M. JEFFREY MORTON, D.M.D., P.A.

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 call first

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NAME: _____ M-F _____ Date of Birth _____

Address: _____

SS# _____ - _____ - _____ Home# _____ Work# _____

Answer all questions by circling either YES or NO. Fill in the blank spaces when indicated.

1. My last physical examination was on (approx.) _____
2. The name and address of my personal physician is _____

Phone # _____

3. Are you now under the care of a physician? YES NO
4. Have you ever had any serious illness or operation? YES NO
 If yes, what was the illness or operation? _____
5. Have you been hospitalized within the past five years? YES NO
 If yes, what was the problem? _____
6. Are you taking any medication or prescription drugs? YES NO

Are You Taking Any of The Following?

Antibiotics or sulfa drugs (penicillin, Erythromycin, Tetracycline, etc.....	YES	NO	Drugs for heart trouble	YES	NO
Anticoagulants (Blood thinners).....	YES	NO	Nitroglycerine	YES	NO
Medicine for high blood pressure.....	YES	NO	Antihistamines	YES	NO
Steroids (cortisone, prednisone).....	YES	NO	Oral contraceptives.....	YES	NO
Drugs that change your mood.....	YES	NO	Hormone pills.....	YES	NO
Aspirin or aspirin-like drugs.....	YES	NO	Anticonvulsant drugs.....	YES	NO
Insulin, orinase or similar drugs for blood sugar problems	YES	NO	Sedatives or sleeping pills.....	YES	NO
			Non-prescription medications	YES	NO
			Other medications _____		

Have You Ever Had Any Of The Following Diseases or Problems?

Diabetes or blood sugar problems.....	YES	NO	History of heart murmur	YES	NO
Asthma or breathing problems.....	YES	NO	Prolapsed mitral valve syndrome ..	YES	NO
Hepatitis, liver or kidney problems.....	YES	NO	Fainting or dizzy spells.....	YES	NO
Epilepsy or seizures	YES	NO	Arthritis or bone problems	YES	NO
Heart valve or bone joint replacement	YES	NO	Other heart problems	YES	NO
High or low blood pressure	YES	NO	Hives or skin rash.....	YES	NO
Family history of diabetes or other problems.....	YES	NO	Veneral diseases.....	YES	NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Penicillin, erythromycin, tetracycline or other antibiotics YES NO
Aspirin, non-steroidal anti-inflammatory drugs or other pain medications..... YES NO
Codeine or other narcotics YES NO
Dental anesthetics (Novacaine, Lidocaine, Carbocaine, Xylocaine, etc.) YES NO
Have you had surgery, radiation treatment or chemotherapy for a tumor?
or cancer of the head or neck? YES NO
Are you pregnant, possibly pregnant, or breast feeding..... YES NO
Do you wear a pacemaker? YES NO
Do you wear contact lenses? YES NO
ARE YOU A SMOKER? YES NO
Have you had any serious trouble associated with past dental treatment..... YES NO

If yes, explain _____

Are you one of the following?
A person with a history of hepatitis, past or present IV drug use, a dialysis patient, AIDS,
ARC, HIV, or a sex partner of an HIV infected person, or person at increased risk..... YES NO
Do you have a disease, condition or problem not listed above..... YES NO
If yes, explain _____

PRIMARY DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME _____
DATE OF BIRTH _____ SS# _____ - _____ - _____
SUBSCRIBER EMPLOYED BY _____
INSURANCE COMPANY _____
INSURANCE COMPANY ADDRESS _____
INSURANCE COMPANY PHONE NUMBER _____
GROUP # _____
DO YOU HAVE SECONDARY DENTAL INSURANCE _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. _____ for all insurance benefits otherwise payable to me for services rendered, I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

To the best of my knowledge, the above information is complete and accurate.

Signature of patient / Responsible party / Guardian _____ Date _____

Reviewed by dentist or office staff _____ Date _____