# Maria Nikolich, D.M.D.

Adult and Children's Dentistry and Orthodontics
236 North Woodbury Road
Pitman, NJ. 08071

NAME: Last_____First_____

ADDRESS:_____

TELEPHONE:HOME_____BUSINESS:_____ CELL:_____

SOCIAL SECURITY #:_____INSURANCE ID #_____

OCCUPATION:_____DATE OF BIRTH:_____
WHO MAY WE THANK FOR REFERRING YOU? _____

## MEDICAL HISTORY:

Your Physician's Name:_____Phone number:_____
Are you currently being treated for any condition?_____
If yes, please explain?_____
Are you currently taking any medications?_____
If yes, please list them?_____
Are you allergic to any medications? Please list._____
Have you had any major or minor surgery? Please list_____

HAVE YOU EVER HAD OR BEEN TREATED FOR (Please circle):

| | | |
|---|---|---|
| Heart Disease | Diabetes | Asthma |
| Rheumatic Fever | Sinus Problems | Hepatitis |
| Heart Murmur | Glaucoma | Arthritis |
| Prosthetic Knees, Joints | Radiation Therapy | Tumors, Growths |
| High Blood Pressure | Liver Problems | Radiation Therapy |
| Low Blood Pressure | Kidney Problems | Tuberculosis |
| Stroke | Dialysis | Cancer |
| Lung Disease | Abnormal Bleeding | Psychiatric Problems |
| Seizures | Sickle Cell Disease | Steroid Therapy |
| Thyroid Problems | Hemophilia | Drug Abuse |
| Chemotherapy | HIV+ | HIV exposed, but negative |

Anything else not listed above:_____

Do you currently smoke?_____How much?_____
Have you smoked in the past and quit?_____How long ago did you quit?_____
Do you chew tobacco?_____ How often?_____
Do you drink alcohol and how much?_____

Have you been warned of dangers of both cigarettes and snuff?_____

## DENTAL HISTORY:

Reason for today's visit:_____
When was your last dental visit?_____
Have you ever been treated for periodontal (gum) disease?_____
How often do you brush your teeth?_____
What texture toothbrush do you use?_____
Do you floss your teeth and how often?_____
What other dental aids do you use to take care of your teeth?_____
When brushing or flossing do your gums bleed?_____
Were you told (or you know yourself) that you grind your teeth at night?_____
Do you (or were you told) snore at night?_____
Do you get headaches and how often?_____
Does your mouth open as wide as you think it should?_____
Does your jaw joint (TMJ) pop or click or is painful?_____
On the scale of 1 to 10, how important are you teeth to you?_____
Is there anything else you would like us to know?_____

## WOMEN ONLY:

Are you pregnant?_____ Are you taking birth control pills?_____

Part of you exam today and in the future will be a review of any medical conditions or medications you are taking (over the counter or prescribed). Dentistry is part of medicine and I will gladly answer additional questions you may have.

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependant(s), have insurance coverage with _____and assign directly to Dr. Nikolich all insurance benefits, if any, otherwise directly payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Signature of patient/guardian: _____relationship:_____

By signing this form I acknowledge that it was filled to the best of my knowledge. It will be my responsibility to notify you of any changes in my medical status.

_____

Signature Date