Laser Dentistry of North Jersey, LLC.
Dr. Richard L. Bucher DMD FAGD
Medical History

Today's Date:____________________

Name:____ Preferred to be called:________________
Last First Middle

Address____
Street City State Zip

Phone: Home__________________ Cell:______________________ Email:_______________________________

Occupation______________________ Work Phone #:______________________

Marital Status: M S D W Date of Birth:_____/______/_____ Sex: M F

SS#:______________________ Whom may we Thank for referring you?__ __________________________________

Emergency Contact:________________________ Relationship:________________ Phone #:__________________

Where and when are the best times to reach you?____

Other family members seen by us:____

Previous Dentist:________________________________ Last visit/treatment:_________________________

Medical Information:

Are you now under the care of a physician?......................Y N
Physicians Name:_____________________________
Phone #:_____________________________________
Address: _____________________________________
Are you in good health now?.......................................Y N DK
Has there been any change in your general health in
The past year?..Y N DK
If yes, what condition is being treated:
____
Date of last physical exam__________________________

Have you had a serious illness, operation of been
hospitalized in the past 5 years?...Y N DK
If yes, what was the problem?______________________________
Are you or have you recently taken any medications…………..Y N DK
List all medications, vitamins,and herbal/dietary supplements taken:
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Medical Information:

Joint Replacement: Have you had joint surgery? ……….Y N
What joint was replaced: hip, knee, elbow, finger, shoulder
Date of surgery:________________________________
Have you EVER taken or are scheduled to start taking ANY
Medication for bone maintenance/replacement such as:
Bisphosphonates, Fosamax, Actonel, Aredia, Zometa, etc.
Y N DK Name:______________Start Date:____________

Women: Are you pregnant: Y N DK How many weeks?_________
Do you take birth control medications or hormone replacement? Y N
Are you nursing? ……………………………………………...Y N

Do you use controlled substances?..Y N
Do you use tobacco-smoke, chew, snuff?.......................................Y N
Do you drink alcohol?..Y N How much in the last 24 hours?________
How much typically per week?______________________________

Allergies: Are you allergic to or have had a reaction to:

Local anesthetic…..Y N DK Aspirin…..Y N DK
Barbiturates, sedatives, sleeping pills………..Y N DK
Latex(rubber)…..Y N DK Iodine…...Y N DK
Hay fever/seasonal allergies…………………Y N DK
Erythromycin……………………………...Y N DK

Penicillin or other antibiotics…..Y N DK
Codeine or narcotics…………..Y N DK
Household bleach………………Y N DK
Foods…………………………...Y N DK
Tetracycline…………………….Y N DK

Sulfa Drugs…..Y N DK
Metals………..Y N DK
Animals………Y N DK
Other:_______________

Please indicate if you have ever had or have not had the following diseases or problems:

Artificial(prosthetic)heart valve…..Y N DK   Previous infective endocarditis…..Y N DK   Damaged valves in transplanted heart…..Y N DK

Congenital heart disease (CHD):   Unrepaired, cyanotic CHD............Y N DK   Repaired (completely) in last 6 months….Y N DK

Repaired CHD with residual defects…..Y N DK

Cardiovascular disease……....Y N DK
Angina………………………..Y N DK
Arteriosclerosis………………Y N DK
Congestive heart failure….…..Y N DK
Damaged heart valves………..Y N DK
Heart attack…………………..Y N DK
Heart murmur………………..Y N DK
Low blood pressure…………..Y N DK
High blood pressure……….....Y N DK
Congenital heard defects……..Y N DK
Mitral valve prolapse…...……Y N DK
Pacemaker…………………....Y N DK
Rheumatic fever……………...Y N DK
Rheumatic heart disease…..…Y N DK
Abnormal bleeding…………...Y N DK
Anemia………………………Y N DK
Blood transfusion……………Y N DK
AIDS or HIV………………....Y N DK

Arthritis…………………….…...Y N DK
Autoimmune disease....……..Y N DK
Rheumatoid arthritis….…….Y N DK
Lupus disease….……..………Y N DK
Asthma….………..…………..Y N DK
Bronchitis….……..….……....Y N DK
Emphysema…………………..Y N DK
Sinus trouble…………….……Y N DK
Tuberculosis…………………Y N DK
Cancer/chemotherapy/
radiation…………………Y N DK
Chest pain on exertion………..Y N DK
Chronic pain…………………Y N DK
Diabetes Type I or II…………Y N DK
Eating disorders…………..…..Y N DK
Malnutrition…………………..Y N DK
Gastrointestinal disease……....Y N DK
Gastric reflux/persistent
heartburn……………..…..Y N DK

Thyroid problems………………..Y N DK
Stroke……...…………..…..……..Y N DK
Glaucoma…………….…………..Y N DK
Hepatitis/jaundice/liver disease….Y N DK
Epilepsy…………………………Y N DK
Fainting spells/seizures……..........Y N DK
Neurologic disorders………...…...Y N DK
Sleep disorder……………...…….Y N DK
Mental health disorders…..……....Y N DK
Recurrent infections……..……....Y N DK
Kidney problems……….………...Y N DK
Night sweats……………….…….Y N DK
Osteoporosis……...……………...Y N DK
Persistent swollen glands in neck..Y N DK
Migraines/severe headaches..…...Y N DK
Severe or rapid weight loss…..…..Y N DK
Sexually transmitted disease……..Y N DK
Excessive urination……..………..Y N DK
Colitis……..…………………..….Y N DK

Do you have any disease, condition, or problem not listed above? ……Y N DK   Please explain:

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I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

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Signature of Patient/Legal Guardian   Date

For Completion By Dentist

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Insurance Information:

Employer:____________________________ Address:____
How long there:_______________________ Occupation:____

Person responsible for account:____________________________
Spouse:_________________________________
Employer:_______________________________ Work #:______________________________
SS#:____________________________________ Birthday:_____/_____/______

Primary Dental Insurance:
Insurance Company:___________________________________ Phone #:__________________________________
Address:____
City State Zip
Group/Plan #:_____________________________
Insured's Name:___________________________ Relationship:___________________________
Insured's Birthday:____/____/____ Insured's ID #:__________________________
Insured's Employer:____
Employer's Address:____
City State Zip

Secondary Dental Insurance:
Insurance Company:___________________________________ Phone #:__________________________________
Address:____
City State Zip
Group/Plan #:_____________________________
Insured's Name:___________________________ Relationship:___________________________
Insured's Birthday:____/____/____ Insured's ID #:__________________________
Insured's Employer:____
Employer's Address:____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments, deductibles, and balances that my insurance does not pay. I also herby authorize payment directly to Laser Dentistry of North Jersey, LLC/ Dr. Richard Bucher of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

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Signature of Patient/ Legal Guardian Date