



**Park Avenue Dental Groop**  
Dr. Simon Roytberg

3508 Park Ave.  
Weehawken, NJ 07086  
Ph. 201-864-4730 Fax: 201-864-4734

www.ParkAveDentalGroup.com

**Please Complete and Return to Office**

Name:		Last	First	Middle
Address:		Street, Apt. or P.O. Box #		City State Zip code
Cell Phone:		Home Phone:		Work Phone:
Age: Yrs.	Birth Date: Mo. Day Year		Email Address	( ) Male ( ) Married ( ) Female ( ) Unmarried ( ) Separated ( ) Divorced
Social Security No: (if child, parents)		Whom may we thank for your referral?		
Occupation:		Employer:	How long employed?	
Employer Address & Phone No:				
Person responsible for bill:		Age:	Relationship to Patient:	( ) Male Social Security No: ( ) Female Driver's License No:
Address:		Street, Apt. or P.O. Box #		City State Zip code
Home Phone:		Work Phone:		Ext. Best Time to Call:
Occupation:		Employer:	How long Employed?	
Employer Address & Phone No:				

Insured Person's Full Name		Date of Birth	
Social Security Number	Relationship to Patient		Work Phone
Insurance Company Name	Group or Union Name		Group or Local Numbers
Employer's Name		Full Address of Employer	
Is insured a patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**CONSENT FOR SERVICES**

Signature of Responsible Party	Relationship	Date
Credit Card Name & Number	Expiration Date	



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Medical History

- 1. Have you been under the care of a medical doctor during the past two years?
9. Have you been a patient in the hospital during the past five years?
10. Have you taken any medicine or drugs during the past two years?
11. Are you currently taking any medication, drugs, pills or herbal remedies...
11. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel...
12. Are you aware of having an allergic (or adverse) reaction to any substance...
13. Have you lost or gained more than 10 pounds in the last year?
14. Are you on a special diet?
15. Check any of the following which apply in either past or present:
16. Do you have any disease, condition or problem not listed?
17. Women: Are you pregnant or think you could be pregnant?
18. Do you use birth control prescriptions?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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Dental History

- 1. What is the reason for your visit today?
2. Date of last dental visit Last dental cleaning Last full mouth X-Rays
3. What was done at your last dental visit?
4. Previous Dentist's Name Address/State/Zip Telephone
5. How often do you have dental examinations?
6. How often do you brush your teeth? How often do you floss?
7. Have you ever used or are currently using topical fluoride?
8. What other dental aids do you use?
9. Do you have any dental problems now?
10. Check any of the following which apply in either past or present:
11. Are you satisfied with your teeth's appearance?
12. Would you like to keep all of your teeth all of your life?
13. Do you feel nervous about dental treatment?
14. Have you ever had an upsetting dental experience?
15. Have you ever been told to take a pre-medication prior to dental treatment?

Patient / Guardian Signature Date