_____ Today's Date_____

Patient's Name:_____ Occupation:_____ Name of Spouse or Parent:_____

Date of Birth:_____ Employer:_____ How Long?____ Spouse or Parent's Occupation:_____

Address:_____ Work Phone:_____ Name of Person Responsible for Account:

City:_____ State_____ Zip_____ Cell Phone:_____ _____

Home Phone:_____ Who referred you to our practice?:_____

Social Security #:_____ Name and Phone of a Friend or Relative who could be contacted in an emergency:_____

INSURANCE INFORMATION · 1st COVERAGE

Name of Subscriber:_____

Birthdate of Subscriber:_____Relationship to Patient_____

Social Security #_____

Employer_____

Address_____

Insurance Company_____

Policy/Group #_____

Union and Local #_____

How much is your deductible?_____

How much have you used?_____

Maximum Annual Benefit?_____

INSURANCE INFORMATION · 2nd COVERAGE

Name of Subscriber:_____

Birthdate of Subscriber:_____Relationship to Patient_____

Social Security #_____

Employer_____

Work Phone_____

Insurance Company_____

Policy/Group #_____

Union and Local #_____

How much is your deductible?_____

How much have you used?_____

Maximum Annual Benefit?_____

DENTAL HEALTH SECTION

If you are currently having any dental pain or discomfort, please describe:_____

If there is another dental problem other than above, please describe:_____

Are you pleased with the appearance of your smile? If not, what would you like to change?:_____

How long has it been since your last dental visit?_____

List the type of toothbrush you use (soft, hard, electric, etc.) and list any accessory oral hygiene aids you may use such as floss, waterpic, stimudent, sonicare, etc:_____

If you have ever had instructions in oral hygiene, list the source of the instructions (e.g.: "Dental Hygienist", "Teacher", "T.V.", "Dentist", "www", etc):_____

Do your gums bleed easily? Yes No

Are any of your teeth sensitive to sweets? Yes No

Are any of your teeth sensitive to cold? Yes No

Are any of your teeth sensitive to pressure? Yes No

Do you usually have a lot of cavities? Yes No

Do you ever grit or grind your teeth? Yes No

biteguard _____ when_____

Are you aware of a breath problem? Yes No

Have you ever had Nitrous/Oxygen (Laughing gas) during dental treatment? Yes No

Have you ever had orthodontic treatment? Yes No

who_____when_____

Have you ever had periodontal treatment? Yes No

who_____when_____

Have you ever had any traumatic injuries or accidents involving your mouth, teeth, or jaws? Yes No

describe_____ when_____

Do you desire to save your natural teeth even if extensive dental restoration is required? Yes No Not Sure

(Rev.06/09)

HEALTH INFORMATION

MEDICAL HEALTH SECTION

List all medical problems or conditions for which you are under a physician's care or are currently receiving treatment:

_____

_____

_____

_____

_____

List all previous hospitalizations and surgeries, noting only year and reason or type of surgery (e.g.: "1958 appendectomy")

_____

_____

_____

_____

_____

List any and all drugs or medications that you are currently taking:

Drug/Dose	Purpose

Physician's Name(s):

_____

_____

_____

List any known allergies to penicillin, local anesthetic, aspirin, codeine, other drugs or substances:

_____

_____

_____

Do you have any, or have you had any of the following diseases or problems? If so, please circle:

Rheumatic Fever	Nervous condition	Hepatitis	Frequent urination
Rheumatic Heart Disease	Anemia	Jaundice	Dry mouth
Congenital-Heart Malformations	Abnormal bleeding after extraction	Delayed healing	Arthritis
Heart Murmur	Fainting spells	Bruise easily	Tuberculosis
Heart trouble or Angina	Chest pain	Glaucoma	Persistent cough
Heart Attack	Trouble breathing	Psychiatric treatment	Any type of Venereal Disease
Stroke	Night sweats	Hayfever	Chronic headache
High Blood Pressure	Seizures	Asthma	Chronic sore jaw muscles
Artificial Joints; hip, knee, etc.	Diabetes	Ulcers	HIV/AIDS

Other _____ Pregnancy (due date) _____

Please add any additional information you feel may be helpful.

CONSENT: Thank you for your care in completing this form. I consent to treatment by Steven Prince, DMD and his staff.
ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due. I understand that the processing of insurance claims is a courtesy and does not relieve me of my financial obligation. I also authorize the dentist to release any information required for an insurance claim.

Signature _____ Date _____

Doctor's Notes: