

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)

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: