PRINCETON DENTAL

PATIENT INFORMATION

DATE: ____________________

First Name: ______________________________ Last Name: ____________________
Address: ______________________________ City: ____________________ State: ________ Zip ________
Home Phone: _____ - _______ - _______ Work Phone: _____ - _______ - _______ Ext: ______ Cell Phone: _____ - _______ - _______
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Date of Birth: _____ / _____ / _____ Age: _____ Social Security No.: _______ - ______ - _______
E-Mail: ______________________________ I would like to receive correspondence via E-Mail ☐ Yes ☐ No
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ None
Student Status: ☐ Full Time ☐ Part Time
If Full Time, Name of School: ______________________________ City/State of School: ____________________
How did you hear about us? ______________________________

RESPONSIBLE PARTY INFORMATION

First Name: ______________________________ Last Name: ____________________
Address: ______________________________ City: ____________________ State: ________ Zip: ________
Home Phone: _____ - _______ - _______ Work Phone: _____ - _______ - _______ Ext: ______ Cell Phone: _____ - _______ - _______

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Social Security No. _______ - ______ - _______ Date of Birth: _____ / _____ / _____
Employer: ______________________________ Work Phone: _____ - _____ - _____ Ext: __________
Insurance Co. ______________________________ Group No. ____________________ ID No. ____________________
Insurance Co. Address: ______________________________ City: ____________________ State: ________ Zip: ________
Insurance Co. Phone No.: ______________________________

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: ______________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Social Security No. _______ - ______ - _______ Date of Birth: _____ / _____ / _____
Employer: ______________________________ Work Phone: _____ - _____ - _____ Ext: __________
Insurance Co. ______________________________ Group No. ____________________ ID No. ____________________
Insurance Co. Address: ______________________________ City: ____________________ State: ________ Zip: ________
Insurance Co. Phone No.: ______________________________

FULL TIME COLLEGE STUDENTS MUST SEND PROOF OF STUDENT STATUS TO INSURANCE COMPANY EVERY SEMESTER

TO OUR PATIENTS: Although dentists primarily treat the area of the mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you are taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. **ALL ANSWERS ARE KEPT CONFIDENTIAL.**

What brought you to our office today? ______________________________
Is there anything else you wanted done or looked at today? ______________________________
When did you last visit a dentist? ____________________ If child, is this your first visit? ____________________
What was done during your last visit? ______________________________
Previous Dentist: ____________________ Reason for leaving: ____________________
Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
Are you interested in whitening your teeth? ☐ Yes ☐ No

If you have not had regular dental treatment, what is the reason? ______________________________
Do you have or ever had any of the following:

☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to: ☐ Hot ☐ Cold ☐ Sweets
☐ Facial Pain ☐ Abscesses ☐ Unpleasant Odor ☐ Broken Fillings
☐ Ulcers/Sores/Boils ☐ Ear Pain ☐ Abnormal Growths

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what condition? ____________

Have you ever been hospitalized or had major surgery? ☐ Yes ☐ No If yes, for what condition? ____________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, for what condition? ____________

Please list all the medications you are taking: ____________

Do you use tobacco? If yes, how much? ____________

Are you on a special diet? If yes, what kind? ____________

WOMEN: Are you pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you taking contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Metal ☐ Local Anesthetics ☐ Other: ____________

Pharmacy: ____________ Phone No.: ____________

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve**
- ☐ Artificial Joint**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Diabetes
- ☐ Dialysis
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Diarrhea
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur**
- ☐ Heart Pace Maker**
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hormone Treatment
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse**
- ☐ Parathyroid Disease
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever**
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ TMJ/Pain in Jaw
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

** These conditions may require medication.

Have you had any of the following surgically place: ☐ Pins ☐ Screws ☐ Rods ☐ Plates ☐ Implants ☐ Other

If you answer yes to any of the above, when were they placed? ____________

Please list any condition not mentioned above: ____________

Primary Medical Doctor: Name: ____________ Phone No.: ____________

Cardiologist: Name: ____________ Phone No.: ____________

Orthopedic Surgeon: Name: ____________ Phone No.: ____________

Oncologist: Name: ____________ Phone No.: ____________

Other: ____________

IF YOU MUST CANCEL YOUR APPOINTMENT WE URGE YOU TO GIVE US AT LEAST 48 HOURS NOTICE SO THAT PATIENTS ON OUR WAITING LIST CAN BE SCHEDULED IN YOUR PLACE. FAILURE TO GIVE US 48 HOURS NOTICE COULD RESULT IN A BROKEN APPOINTMENT CHARGE. PLEASE INITIAL____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE