PRINCETON DENTAL

PATIENT INFORMATION

DATE:____________________

First Name:____________________ Last Name:____________________

Address:____________________ City:____________ State:______ Zip:__________

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____ Ext:_____ Cell:_____-_____-_____

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

Text ❑ Yes ❑ No

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired ❑ None Driver's License #:____________________

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:_____-_____-_____

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.____________________

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?____________

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 ❑ Facial Pain ❑ Ulcers/Sores/Boils ❑ Difficultly Chewing ❑ Abscesses ❑ Ear Pain ❑ Unpleasant Odor ❑ Abnormal Growths ❑ Broken Fillings ❑ Sensitivity to: ❑ Hot ❑ Cold ❑ Sweets ❑ Air