Dental Care PRINCETON 301 North Harrison Street, Suite 440, Princeton, NJ 08540 • (609) 454-0777 • DentalCarePrinceton.com

Patient's Name:______________________ How do you prefer to be addressed?__________ Sex (Circle One): Male Female
Birth Date:____ /____ /____ Age:__________ Marital Status (Circle One): Single Married Widowed Separated Divorced
SS#:______________ Mailing Address:________________________ City:__________ State:____ Zip:______
E-mail: ____________________________ Home Phone: (_____) ___________ Cell: (_____) ___________
Dental Insurance Carrier: ___________________ Policy Holder: __________________ Policy Holder DOB: ________
Insurance ID Number: _______________ Work Phone: (_____) ___________
Occupation:__________________________ Employer: ______________________________
If Student, Name of School/College: PT FT ________________________ City: ___________ State:____ Zip:______
Who can we thank for referring you to our office? ______________________________

If the person responsible for payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip.

Name of Responsible Party: ________________________________ Relationship to Patient: ____________
Mailing Address: ___________________________________ City: ______________ State: _____ Zip: ______
E-mail: ____________________________ Home Phone: (_____) ___________ Cell: (_____) ___________
Work Phone: (_____) ___________ Occupation: __________________________ Employer: ____________

Medical History

Date of last complete physical:________ Medical Doctor's Name: ______________ Doctor's Phone #:(____) ________
Are you taking any medication, vitamins, or supplements? Bisphosphonates? Yes / No Please list: ______________
Do you smoke? Yes ______ No ______ If yes, how much a day?______________________
Are you pregnant? Yes ______ No ______ If yes, how many months? ______________________
Are you allergic to: (Select all that apply) Penicillin Codeine Local injected anesthetic Latex Other: __________
Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

____

Have you been told that you need to take antibiotics prior to dental cleanings or other treatment? Yes___ No___
Medication & Reason: ____
Do you have or have you ever had any of the following? Check all that apply:

____ Heart attack	____ Anemia	____ Ulcers	____ Excessive urination	____ Soreness in jaw
____ Heart murmur	____ Prolonged bleeding	____ Herpes	____ Sensitivity to epinephrine	____ Is it hard for you to open wide?
____ Heart condition	____ High or low blood pressure (circle one)	____ AIDS/HIV positive	____ Implants	____ Snoring
____ MVP		____ Asthma	____ Headaches/Migraines	____ Dry mouth
____ Pacemaker	____ Diabetes	____ Hay fever	____ Pain/Soreness (circle one) ears, eyes, face	____ Bad breath or sour taste
____ Stroke	____ Hepatitis	____ Sinus trouble		____ Sensitivity to hot and cold
____ Malignancies	____ Jaundice	____ Persistent cough	____ Stiff neck, jaw pain, or TMJ (circle one)	____ Burning sensations in mouth
____ Radiation treatments	____ Arthritis	____ Psychiatric care or Nervous problems		____ Bleeding gums
____ Thyroid Disease	____ Rheumatism		____ Clicking or popping in jaw	____ Food catching between teeth
____ Epilepsy	____ Joint replacements	____ Narrow angle glaucoma	____ COVID-19; Date of positive test result: ________	

What is most important to you about your teeth?______________________________
How would you rate the appearance of your smile? (Select one) Excellent ☐ Good ☐ Fair ☐ Poor ☐
If you could change anything about your smile, what would it be?______________________
Does having dental treatment make you afraid or nervous? Y ☐ N ☐ If yes, what specific things bother you? __________

Communication Preferences:

☐ Do not leave a detailed message ☐ Office may leave a detailed message which may contain medical/dental information at the following phone number(s): ☐ Cell ☐ Home

Is there anyone other than the patient we may speak to regarding any dental treatment information?

Name of Person:______________________ Relationship to Patient: ______________________

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Princeton to check and verify my credit and/or employment history. I further understand that Dental Care Princeton will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I give permission for phone calls and visits to be recorded for internal training purposes. If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient. We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

I agree that, should I test positive for COVID-19 within 14 days following my dental appointment, I will immediately contact my doctor.

Signature of Patient or Guardian: ______________________________ Date:_____ /_____ /_____