Plainsboro Dental Care

Welcome!

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. Please take a few minutes to read and complete these forms so we can better assist you with your dental needs.

Patient Information

Date _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ Cell Phone _____ Work Phone _____

State _____ Zip _____ Soc. Sec. # _____ Birthdate _____

Sex: ☐ M ☐ F ☐ Single ☐ Married Preferred method of contact _____ Email _____

Whom may we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Contact Phone _____

City _____ State _____ Zip _____

Responsible Party Employed by _____ Business Phone _____

Business Address _____ Occupation _____

Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Contact Phone _____

City _____ State _____ Zip _____

Insured Employed by _____ Business Phone _____

Primary Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Secondary Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

Address _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath . . . . . ☐
Bleeding Gums . . . . . ☐
Blisters on Lips or Mouth . . . . . ☐
Finger Nail Biting . . . . . ☐
Grinding Teeth . . . . . ☐
Lip or Cheek Biting . . . . . ☐
Loose Teeth or Broken Fillings . . . . . ☐
Orthodontic Treatment . . . . . ☐
Pain Around Ear . . . . . ☐
Periodontal Treatment . . . . . ☐
Sensitivity to Cold . . . . . ☐
Sensitivity to Heat . . . . . ☐
Sensitivity to Sweets . . . . . ☐
Sensitivity When Biting . . . . . ☐
Frequent Headaches . . . . . ☐
Jaw, Head or Neck Injuries . . . . . ☐
Jaw Difficulty: Clicking and/or Pain . . . . ☐
Tooth Pain . . . . . ☐