Prestige Dental Network

855-My Prestige
855-697-7378

PATIENT INFORMATION

Patient Name _____
Last First MI

Preferred Name _____ Birthdate _____ M _____ F _____

S.S. # _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Cell Phone (_____) _____ E-Mail _____

Employer _____ Occupation _____

Can we contact you at work? ❑ Yes ❑ No

When & Where Are Best Times To Reach You? _____

Whom May We Thank For Referring You To Our Practice? _____

Whom May We Contact In The Event of An Emergency?

Name _____ Relationship _____ Phone No. _____

INSURANCE INFORMATION

Name of Insured _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birthdate _____ ID# _____ Group # _____

Insured's Home Address _____
Street State Zip

Insured's Employer Name _____

Address _____
Street State Zip

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name _____ Telephone # _____

COSMETIC INFORMATION

Are you pleased with the appearance of your teeth when you smile?	❑ Yes	❑ No
Do you have stains on your teeth that won't brush off?	❑ Yes	❑ No
Are your teeth as white as you'd like them to be?	❑ Yes	❑ No
Do you get canker sores?	❑ Yes	❑ No
Do you have any concerns about bad breath odor?	❑ Yes	❑ No
Do you have old black fillings or a crown with dark margins around them you'd like replaced with the newer tooth color restorations?	❑ Yes	❑ No

If you could change anything about the appearance of your smile, what would that be?

_____

_____

Health Information

Are you allergic to any of the following? (check boxes that apply)

- ❑ Aspirin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry
- ❑ Latex
- ❑ Penicillin/Amoxicillin
- ❑ Sedatives
- ❑ Sulfa Drugs
- ❑ Tetracycline
- ❑ Other

Please list additional drugs that cause allergic reactions? _____

_____

Are you taking any medication? (Please list all)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

1. **Have you ever had any of the following? (check boxes that apply)**

- ❑ Heart Problems
- ❑ Blood Pressure Problems
- ❑ Circulatory Problems
- ❑ Nervous Problems
- ❑ Radiation Treatment
- ❑ Artificial Heart Valves or Joints
- ❑ Recent Weight Loss
- ❑ Back Problems
- ❑ Diabetes
- ❑ Respiratory Disease
- ❑ Pacemaker
- ❑ Epilepsy
- ❑ Headaches
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Cancer
- ❑ Psychiatric Care
- ❑ TB
- ❑ General Allergies
- ❑ Blood Disease
- ❑ Hemophilia (Prolonged Bleeding)
- ❑ Jaw or Ear Pain (TMJ)
- ❑ Special Diet past or present (like Fen-Phen)
- ❑ Swollen Neck Glands
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ A.I.D.S. / HIV
- ❑ Stroke
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Chemical Dependency
- ❑ Arthritis
- ❑ Chemotherapy
- ❑ Acid Reflux
- ❑ Other_____

2. Name of family physician _____ Phone _____
3. Date of last physical? _____

		Yes	No
4.	Are you under medical treatment now?	❑	❑
5.	Have you had any major operations? If so, what	❑	❑
6.	Have you ever had a serious accident involving head/mouth injuries?	❑	❑
7.	Do you smoke or use tobacco in any form?	❑	❑
8.	Are you on a diet at this time?	❑	❑
9.	Are you in general good health at this time?	❑	❑
10.	Have previous cuts healed slowly or presented other complications?	❑	❑
11.	Are you pregnant? Due Date	❑	❑
12.	Do you have a history of fainting?	❑	❑
13.	Is there any other information that should be known about your health or previous dental visits?	❑	❑

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Today's Date _____ Signature _____

Print Name _____