BARRY H. STEVENS, D.D.S., P.A.
PRACTICE LIMITED TO ENDODONTICS

2365 Park Street • Jacksonville, FL 32204
T 904.388.1220 • F 904.388.8220
www.firstcoastendo.com

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ S.S. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ _____ Medical Doctor _____ _____ Referred By _____ _____
FIRST NAME LAST NAME LAST NAME FIRST NAME LAST NAME

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Nearest relative not living with you _____ _____ Tel.(_____) _____
FIRST NAME LAST NAME

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

(If self, skip to next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ _____ Relation _____ S.S.# _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

❶ PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____
ADDRESS

_____ _____ _____ Tel.(_____) _____
CITY STATE ZIP

Group # _____ **Group Name** _____

Insured Party _____ _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

Tel.(_____) _____ S.S. # _____

I.D. # _____

❷ SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____
ADDRESS

_____ _____ _____ Tel.(_____) _____
CITY STATE ZIP

Group # _____ **Group Name** _____

Insured Party _____ _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

Tel.(_____) _____ S.S. # _____

I.D. # _____

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NAME _____ _____ AGE _____ ☐ M ☐ F PATIENT # _____
FIRST LAST SEX SOCIAL SECURITY #

DENTAL HISTORY

Referring Dentist _____ _____ City _____
FIRST NAME LAST NAME

Briefly describe your problem: _____

How long have you had this problem? _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

Check (X) all that apply:

PAIN: ☐ Never *(If checked, go to SWELLING)* ☐ In the Past ☐ Today

LOCATION : ☐ Upper Left ☐ Upper Right ☐ Upper Front ☐ Lower Left ☐ Lower Right ☐ Lower Front

DURATION: ☐ Seconds ☐ Minutes ☐ Hours ☐ Constant

QUALITY: ☐ Dull pain ☐ Throbbing pain ☐ Sharp pain

PAIN SCALE *(check (X) 0-10)*:

Mild ***Severe***

0	1	2	3	4	5	6	7	8	9	10

PROVOKED BY: ☐ Cold ☐ Hot ☐ Biting ☐ Sweet ☐ Spontaneous (unprovoked) ☐ Other _____

SWELLING: ☐ None ☐ In the Past ☐ Today

Today's Anxiety Level: (0-10) _____

I have answered above completely and accurately.

Signature (patient or parent/guardian) _____ **Date** _____

Doctor signature _____ **Date** _____

Print Form