# STEVEN E. NAUSS, D.D.S.

## PATIENT INFORMATION

Patient's Name _____ Male Female Date of Birth ____/____/____
(circle one) Single Married Divorced Separated Widow

Street Address _____ No. of Years _____ Home Phone (  ) ____ - _____

City, State, Zip Code _____ Patient's Social Security # _____ - _____ - _____

Patient employed by _____ No. of Years _____ Business Phone (  ) ____ - _____

Spouse Name and employer _____ Business Phone (  ) ____ - _____

Name and telephone number of nearest relative not living with you _____

Person responsible for this account _____

Do you have dental insurance (  ) Yes (  ) No

If yes, name of primary insurance company _____ Number _____

If yes, name of secondary insurance company _____ Number _____

Primary's social security number _____ D.O.B. _____ Secondary's social security number _____ D.O.B. _____

Medical Insurance _____ Number _____

I request payment of insurance benefits to be made to Steven E. Nauss, D.D.S., on my behalf, for any services furnished. I understand that I am responsible for all fees at time of service, regardless of insurance coverage, including any legal fees or costs incurred in the collection of this account if it becomes delinquent.

☐ I understand that a credit report may be obtained

Method of Payment: I prefer ☐ Cash ☐ Check ☐ Credit Card

Date _____ Signature _____

## DENTAL HISTORY

Date of last x-rays _____

Type of x-ray taken _____

Date of your last dental cleaning _____

Texture of toothbrush _____ Frequency of brushing _____

Flossing (  ) Yes (  ) No Frequency of flossing _____

Any other oral hygiene aids _____

Is this child taking Fluoride supplements? (  ) Yes (  ) No

Is your home on town water supply _____ or well water? _____

**DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)**

☐ Teeth sensitive to cold, heat, sweets or pressure
☐ If yes, what areas _____
☐ Bleeding gums? How long _____
What areas _____
☐ Food Impaction
☐ Clenching or grinding
☐ Swelling or lumps in mouth

☐ Frequent blisters on lips or mouth
☐ Pain around ear
☐ Unusual sounds in ear while eating
☐ Bad breath
☐ Unpleasant taste
☐ Unfavorable dental experience

☐ Complications from extractions or other dental treatment
☐ Periodontal treatment (gum disease, pyorrhea)
☐ Orthodontic treatment
☐ Mouth breathing
☐ Oral habits (fingernail biting, cheek biting, etc.)
☐ Cigarettes, pipe or cigar smoking
☐ No. of Cigarettes per day

☐ Do you wear removable dental appliances _____ How long? _____ Comfortable? _____

Chief dental complaint _____

Referred by _____ Dentist's name _____

Address _____

Phone _____