Patient Intake Form
(Confidential)

Patient Number: ____________
Date: ____________

Welcome

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Name ____________
SSN#/SIN ____________ Birth Date ____________
Address ____________
City/State ____________
Email ____________
Drivers License # ____________ State ____________

Home Phone ____________
Cell Phone ____________

Check appropriate box:

☐ Minor ☐ Separated
☐ Single ☐ Divorced
☐ Married ☐ Widowed

If Student, Name of School/College ____________ City ____________
Patient or Parent/Guardian's Employer ____________
Business Address ____________ City ____________
Spouse or Parent/ Guardian's Name____________
Employer ____________
Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency

Name ____________
Home Phone ____________
Cell Phone ____________

Responsible Party

☐ SELF / information is same as above

Name of Person Responsible for this Account ____________
Address ____________
City/State ____________
Email ____________
Employer ____________

Relationship to Patient ____________
Home Phone ____________
Cell Phone ____________
SSN#/SIN ____________
Birth Date ____________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ OTHER ☐ I wish to discuss the office's payment policy.

Insurance Information

☐ SELF / information is same as above

Name of Insured ____________
City/State ____________
Email ____________
Employer ____________
Employer Address ____________
City/State ____________
Insurance Company ____________
Insurance Co. Address ____________
How Much is Your Deductible? ____________ Max. Annual Benefit____________

Relationship to Patient ____________
Home Phone ____________
Cell Phone ____________
SSN#/SIN ____________
Birth Date ____________
Date Employed ____________
Policy ID # ____________
How Much Have You Used? ____________

Do you have Additional Insurance ☐ Yes ☐ No

Name of Insured ____________
City/State ____________
Email ____________
Employer ____________
Employer Address ____________
City/State ____________
Insurance Company ____________
Insurance Co. Address ____________
How Much is Your Deductible? ____________ Max. Annual Benefit____________

Relationship to Patient ____________
Home Phone ____________
Cell Phone ____________
SSN#/SIN ____________
Birth Date ____________
Date Employed ____________
Policy ID # ____________
How Much Have You Used? ____________

Over Please

Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized or an surgical operation or serious illness with the last 5 years:	☐	☐
If yes, please explain: ______________		
3. Are you taking any medications, including non-prescription medicine: If yes, what medication(s, are you taking? ______________	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any other cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulta Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________	☐	☐
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only		
Are you pregnant / think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stomach Troubles/Ulcers	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Chest Pains	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Easily Winded	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Stroke	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Hay Fever/Allergies	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Kidney Diseases	☐	☐	Joint Replacement or Implant	☐	☐	Liver Disease	☐	☐
AIDS or HIV Infection	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
Thyroid Problem	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐

Other: ______________

Patient Dental History

Name of Previous Dentist and Location: ______________ Date of Last Exam: ______________

	Yes	No
1. Do your gums bleed while brushing or tossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth:	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date or placement: ______________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that or providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____

Signature of patient (parent/guardian if minor)