Patient Intake Information

Patient Information

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Home □ Cell Alt Phone: _____

Email: _____

Emergency Contact: _____
Name Relationship Phone

What is the reason for your visit / Chief Complaints? _____

_____

How did you hear about us? _____

Primary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with the above - named Insurance Company and assign directly to Dr.

Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative

Name of Patient, Parent, Guardian, or Personal Representative (Print)

_____ _____
Date Relationship to Patient

Dental History and Oral Health

Date of last dental visit: _____ Date of last dental X-ray: _____

Have you ever been treated for periodontal disease? □ Yes □ No

Please check any dental conditions that apply to you:

□ Pain in Jaw (TMJ) □ Teeth Grinding / Clenching □ Use Tobacco Products □ Swollen / Bleeding Gums

□ Mouth Sores □ Broken / Loose Teeth □ Sensitive Teeth □ Difficulty Chewing / Swallowing

□ Crooked / Spaced Teeth □ Tooth Color / Appearance

Are you in pain? □ Yes □ No Do you experience any fears or anxieties related to dental treatment? □ Yes □ No

If Yes, please explain: _____

_____

Medical History

Primary Care Provider (Name and Phone): _____

Date of last physical: _____ Are you taking birth control? □ Yes □ No □ Not Applicable

Are you currently pregnant or nursing? □ Yes □ No □ Not Applicable Estimated due date, if applicable: _____

Please list any prior hospitalizations or surgeries, including dates: _____

_____

Is the patient currently using alcohol or drugs (including tobacco)? □ Yes □ No

If yes, Type: _____ Frequency: _____ Amount: _____

Do you require antibiotics prior to dental procedures? □ Yes □ No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years? □ Yes □ No

Are you currently taking or have you ever taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates? (e.g. ZOMETA, AREDIA)? □ Yes □ No If yes, for how long? _____

Are you allergic or have you ever had an adverse reaction to any of the following?

□ None □ Amoxicillin □ Aspirin □ Codeine □ Epinephrine □ Latex □ Ibuprofen

□ Metals □ Penicillin □ Sulfa □ Tetracycline □ Erythromycin □ Z-pack

Please specify any other known allergies: _____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates):

Prescription / Supplement Name	Dosage/ Frequency	Dates

Conditions *(Please check all that apply)*

- ☐ None
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Type & Age: _____
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  Type: _____
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
  Type: _____
- ☐ Drug Addiction
- ☐ Epilespy
- ☐ Excessive Bleeding
- ☐ Fainting / Dizziness
- ☐ Hearing Impairment / Loss
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type: _____
- ☐ Heart Trouble
  Type: _____
- ☐ Hepatitis
  Type: _____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease / COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
  Type: _____
- ☐ Organ Transplants
  Type: _____
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other Disease / Illness
  Type: _____
  _____

_____ _____

Patient Signature **Date**

_____ _____

Doctor's Signature **Date**