New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Sex: ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Partnership ❑ Widowed

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about our practice or whom may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate:_____

Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security #_____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security #_____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Reason for today's visit: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Phone: _____

Check if you have any problem with the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between certain teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to any of the following: cold, hot, sweets
❑ Sensitivity when biting
❑ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, give approximate dates: _____

Women: are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control? ❑ Yes ❑ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, etc.
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	**Diagnosis**

Please list any allergies you may have:

Allergy	**Allergy**

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ _____

Patient or Guardian Signature *Date*