

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name		First Name		Middle Initial	Social Security Number	
Street Address			City	State	Zip Code	Date of Birth
Age						
Primary Phone #		Email Address				

Male Female
 Single Married Divorced Separated Widow

PRIMARY INSURANCE

Holder: _____
 Insurance Co: _____
 Group #: _____
 Member id: _____
 Phone: _____

SECONDARY INSURANCE (if applicable)

Holder: _____
 Insurance Co: _____
 Group #: _____
 Member id: _____
 Phone: _____

EMPLOYER

Name: _____
 Address: _____
 City, State Zip: _____
 Occupation: _____
 Phone: _____

EMERGENCY CONTACT

Name: _____
 Relationship: _____
 Phone 1: _____
 Phone 2: _____

May we share personal medical information? Yes No

CURRENT MEDICATIONS

ALLERGIES

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient / Guardian Signature

(If guardian, write name please)

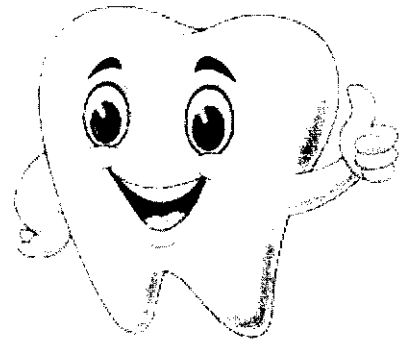
Date

PATIENT MEDICAL & DENTAL HISTORY

ADDITIONAL QUESTIONS

Yes No

- Do you drink? # per day _____
- Do you smoke? # per day _____
- Do you vape? Cannabis Nicotine
- Do you use any edible cannabis or CBD products?
- Pregnant or nursing?
- Have you ever taken an antibiotic prior to dental treatment?
- Are you satisfied with your teeth's appearance?
- Would you like to keep your teeth all your life?



Previous hospitalizations / surgeries

Current medications

Allergies

Other medical concerns

Previous Dentist's name

What is the reason for your visit today?

Do you have any dental problems now? If yes, please describe

Do you feel nervous about having dental treatment? if yes, what is your biggest concern?

Have you ever had an upsetting dental experience? If yes, please describe

Who may we thank for referring you to our office?

Patient / Guardian Name: _____

Patient / Guardian Signature: _____

Date: _____

PATIENT MEDICAL & DENTAL HISTORY

PATIENT NAME: _____ DOB: _____ Date: _____

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems or Disease | <input type="checkbox"/> | <input type="checkbox"/> | Scarring / Keloids |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis – type: | <input type="checkbox"/> | <input type="checkbox"/> | Seizures / Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Problems | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Skin Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Carotid Artery Disease | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Special Diet / Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> | Spinal Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Problems | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Feet or Ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Treatments | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Neck Glands |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Temporal Arteritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Problems | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Neurological Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorder or Care | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Head Injury | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease | <input type="checkbox"/> | <input type="checkbox"/> | Other |

DENTAL HISTORY

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bad Breath | <input type="checkbox"/> | <input type="checkbox"/> | Food collection in teeth | <input type="checkbox"/> | <input type="checkbox"/> | Mouth pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Gums | <input type="checkbox"/> | <input type="checkbox"/> | Foreign objects in mouth | <input type="checkbox"/> | <input type="checkbox"/> | Orthodontics |
| <input type="checkbox"/> | <input type="checkbox"/> | Blisters (mouth or lips) | <input type="checkbox"/> | <input type="checkbox"/> | Grinding teeth | <input type="checkbox"/> | <input type="checkbox"/> | Pain around ear |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning Sensation | <input type="checkbox"/> | <input type="checkbox"/> | Gums swollen/tender | <input type="checkbox"/> | <input type="checkbox"/> | Periodontal treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Chewing on one side | <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain/tiredness | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Clicking or Popping Jaw | <input type="checkbox"/> | <input type="checkbox"/> | Lip or cheek biting | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to heat |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry Mouth | <input type="checkbox"/> | <input type="checkbox"/> | Loose teeth / broken fillings | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to sweets |
| <input type="checkbox"/> | <input type="checkbox"/> | Fingernail biting | <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing | <input type="checkbox"/> | <input type="checkbox"/> | Other |

_____ Date of last dental visit?

_____ How often do you have dental examinations?

_____ Date of last full mouth x-rays?

_____ How often do you brush/floss?

_____ Date of last dental cleaning?

_____ What other dental aids do you use?

Provider Name

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