New Patient Dental Intake Form

Patient Information

Name: ____________________ Birthdate: ____________________
Address: ____________________ City: ____________ State: ________ Zip: ________
Home Phone: ____________ Work Phone: ____________ Email: ____________________
Social Security #: ____________________ Preferred Pharmacy: ____________________
Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Partnership ☐Widowed
Employer or School: ____________________ Phone: ____________________
Address: ____________________ City: ____________ State: ________ Zip: ________
Spouse / Partner / Parent Name: ____________________
Emergency Contact: ____________________ Phone: ____________________
How did you learn about our practice or whom may we thank for referring you? ____________________
Who is responsible for your account and payment? ____________________
Address: ____________________ City: ____________ State: ________ Zip: ________
Phone: ____________ Email: ____________________ Birthdate: ____________________

Dental Insurance

Insurance Company: ____________________ Phone: ____________________
Plan Holder's Name: ____________________ Plan Holder's DOB: ____________________
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 problems 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 your teeth? ____________

Medical History

Primary 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 Abnormality
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congetital heart lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmer
- ☐ 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 using and the correlating diagnosis:

____________________ ____________________

Please list any allergies that you may have:

____________________ ____________________

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