

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:

- | | |
|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to any of the following: cold, hot, sweets |
| <input type="checkbox"/> Food collection between certain teeth | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> 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