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*