Adult Patient Intake Medical / Dental / Insurance

Patient Information

First Name *

Last Name *

Date of Birth *

Age

Gender

○ Male ○ Female

Address

City

State

Zip

Home Phone

(___) ___-____

Cell Phone

(___) ___-____

Work Phone

(___) ___-____

Ext

Employer or School

How did you find about us? *

Preferred method of contact?

○ Phone ○ Text/SMS ○ Email

Emergency Contact

Cell Number

(___) ___-____

Relationship

Approximate Height

Approximate Weight

For sedation and medication purposes

Medical Information

Have you had a recent exposure to any communicable infectious diseases? (Measles, Chicken Pox or Tuberculosis)

○ Yes ○ No

In the last 24 hours have you had a new cough, shortness of breath, fever, chills, diarrhea or other flu-like symptoms?

○ Yes ○ No

Have you previously been or are currently under the care of a health care professional for any kind of specific condition or syndrome?

○ Yes ○ No

Do you require premedication prior to hygiene (cleaning) appointments or dental treatment?

○ Yes ○ No

Please be sure to take your premedication prior to your appointment.

Have you ever had any major surgeries?

○ Yes ○ No

Please explain

Are you taking any medications (including birth control, vitamins, etc.)

○ Yes ○ No

Please explain

Do you have any known allergies?

○ Yes ○ No

Please explain

FEMALES

Are you pregnant or nursing, or a possibility you could be pregnant?

○ Yes ○ No

Please check any of the following below that you have ever had a bad reaction to

- ☐ Local Anesthetics
- ☐ Codeine
- ☐ Insulin
- ☐ Barbiturates
- ☐ Latex
- ☐ Metals

Metals

- ☐ Ibuprofen
- ☐ Penicillin
- ☐ Aspirin
- ☐ Iodine
- ☐ Other

Other

Have you had or do you have any of the following?

- ☐ Anemia
- ☐ Stroke or Blood Clots, Bleeding Easily
- ☐ Blood Transfusions
- ☐ Heart Disease
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defects
- ☐ Rheumatic Heart Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Pacemaker
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Thyroid/Adrenal Disease
- ☐ Cancer

Date

- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Hepatitis/Jaundice
- ☐ Drug/Alcohol Dependency
- ☐ Mental Illness
- ☐ HIV
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis
- ☐ Eye Disorders
- ☐ Epilepsy
- ☐ Seizures
- ☐ Malignant Hyperthermia
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Smoker
- ☐ Pins, plates, replacement joints

Dental Information

Last dental check-up/cleaning?

How often do you visit the dentist?

How often do you brush your teeth?

How often do you floss your teeth?

Are you having any problems that require immediate attention?
○ Yes ○ No

Please explain

Do any of the following cause tooth discomfort?

- ☐ Sweets
- ☐ Hot
- ☐ Cold
- ☐ Chewing

Do you clench or grind your teeth?
○ Yes ○ No

Have you ever had orthodontic treatment (Braces or Invisalign?)
○ Yes ○ No

Are you interested in straightening your teeth?
○ Yes ○ No

Have you ever considered straightening, bleach, crowns or veneers?
○ Yes ○ No

Do you have spaces you would like closed?
○ Yes ○ No

How do you feel about the appearance of your teeth?

Is there anything else you wish to share/discuss about your teeth or smile?

Primary Insurance

Your insurance company/carrier

Insurance Address

Secondary Insurance (If Applicable)

Your insurance company/carrier

Insurance Address

Insurance Phone Number

(___) ___-____

Employer

Policy holder's name

Policy holder's date of birth

Group or policy number

I.D./Certificate number

Insurance Phone Number

(___) ___-____

Employer

Policy holder's name

Policy holder's date of birth

Group or policy number

I.D./Certificate number

I authorize release to my dental benefits plan administrator and the ADA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

I authorize my insurance company to make payment directly to this dental provider.

As you may know your insurance covers only a percentage of the total fee of services provided and we therefore require a credit card number to accept assignment from your insurance carrier. This is with the understanding that our office will be calling you for authorization to use this credit card to pay the difference not paid by your insurance provider.

I understand that anything not covered by my dental insurance is my full responsibility to pay. Our of ce will help to provide the most accurate estimate possible, but it is ultimately the patients responsibility to know what their insurance coverage details are.

I understand that your office requires me to give **48 hours notice** prior to cancelling or rescheduling my appointments. If I fail to do so or fail to come to my appointment a **$100 fee** may apply. As a courtesy our office will send an email/text appointment reminder to you.

Name and Email of Signing person

First & Last Name *

Email Address *

Signature *

Sign above