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PATIENT INTAKE FORM

Name ______________________ Date ____________

Address ______________________ State __________ Zip __________

Birth Date __________ Gender __________ Age ______ Height __________ Weight ______

Phone ______________ Email ______________ Occupation ______________

Emergency contact ______________ How did you learn about us? ______________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Health concerns

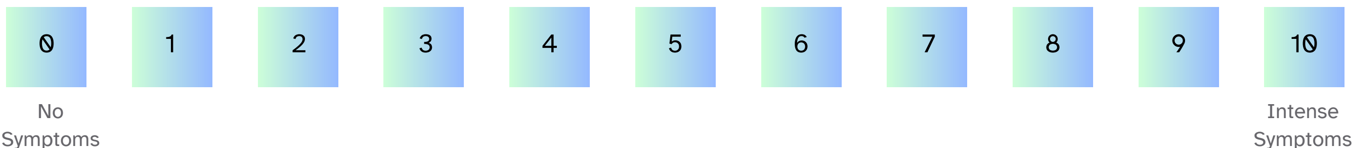
Please mark your Dental Concerns.

- ☐ Cavities
- ☐ Gum Problem
- ☐ Toothache
- ☐ Esthetics
- ☐ Sensitive Teeth
- ☐ Bad Breath
- ☐ Infection
- ☐ Dry Mouth
- ☐ Other ______________

Please check the interested Dental Treatments.

- ☐ Cleanings
- ☐ Gum Problem
- ☐ Esthetics
- ☐ Braces
- ☐ Fillings
- ☐ Teeth Whitening
- ☐ Cavities
- ☐ Dentures
- ☐ Other ______________

Out of 10, mark the severity of your symptoms.



No Symptoms — Intense Symptoms

When Did it start? ______________ What makes it worse? ______________

Have you seen any Doctor/Health Provider for this condition? ______________

If so, when and who? ______________

List all medications currently taking ______________

____

Health and illness History

- [ ] Allergies
- [ ] Neck Pain
- [ ] Migraine
- [ ] Arthritis
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] High BP
- [ ] HIV
- [ ] Chemo
- [ ] ADD/ADHD
- [ ] Digestive Issue
- [ ] Immune Issue
- [ ] Chest Pain
- [ ] Stroke
- [ ] Heart Disorder
- [ ] TMJ
- [ ] Blood Clot
- [ ] Surgery
- [ ] Tonsils
- [ ] Kidney Issue
- [ ] Bladder Issue
- [ ] Menstrual Issues
- [ ] GRED
- [ ] Surgery
- [ ] Osteoporosis
- [ ] Cardiovascular
- [ ] Asthma
- [ ] Epilepsy
- [ ] Thyroid Issue
- [ ] Varicose Veins
- [ ] Other ______________

For Women Only

Are you currently pregnant? ☐ Yes ☐ No

Are you currently Nursing? ☐ Yes ☐ No

Are you currently taking Birth control? ☐ Yes ☐ No

Dental Insurance

Insurance Company ______________________________ Phone ______________

Subscriber's Name ______________________________ Relationship with Subscriber ______________

ID # ______________ Group # ______________ Social Security # ______________

Address ____

Is this Insurance offered by Employer ☐ Yes ☐ No If so, Employer's Name ______________

If so, Employer's Address ______________________________ Phone ______________

I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examnation and diagnose my condition.

Signature ______________ Name ______________ Date ______________