Dental Intake Form

1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male ○ Transgender ○ Genderqueer
○ Agender ○ Genderless ○ Non-Binary ○ Cis Man
○ Cis Woman ○ Trans Man ○ Trans Woman
○ Third Gender ○ Two-Spirit ○ Bigender
○ Genderfluid

Social Security #: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

May we leave a message?
○ Yes ○ No

Employer: _____

Preferred Language:
○ English ○ Spanish ○ Other:

If other, please specify: _____

Race (Please check all that apply):
☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander ☐ Other:

If other, please specify: _____

Ethnicity:
☐ Hispanic/Latino(a)

How did you learn about this office? _____

Who referred you? _____

2. **Emergency Contact Information.**

Emergency Contact Name: _____ Relationship: _____

Address: _____ Apt/Unit #: _____

Phone Number: _____ Alt Phone Number: _____

3. Family Doctor: _____ Telephone #: _____

Other Health Provider: Telephone #:

Pharmacy: Telephone #:

4. Do you have Dental Insurance?

- ○ Yes
- ○ No

5. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Do you have Secondary Insurance?
○ Yes ○ No

6. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

I authorize the release of any medical information necessary to process my claim and payment of benefits.

Signature Date

7. What is the reason for your visit today?

☐ Examination ☐ Emergency ☐ Procedure
☐ Other:

If other, please specify:

8. Please describe your current dental problem(s):

9. Please indicate the date of (month/year):

Last dental visit: _____ Last dental cleaning: _____ Last dental X-rays: _____

10. Please indicate if you have any of the following:

- ☐ Dental pain:
- ☐ Sensitivity:
- ☐ Loose teeth
- ☐ Currently or previously had braces/orthodontic treatment
- ☐ Clench or grind your teeth
- ☐ Eating problems:
- ☐ Bleeding gums with brushing or flossing
- ☐ Jaw concerns:
- ☐ Sores or ulcers in your mouth
- ☐ History of tooth loss (apart from surgical extractions):
- ☐ History of oral surgery:
- ☐ Periodontal (gum) treatments
- ☐ History of root canal

11. If dental pain, specify location(s):

12. If Sensitivity, to:

- ☐ Cold
- ☐ Heat
- ☐ Sweet
- ☐ Pressure

13. If Eating problems:

- ☐ Difficulty chewing
- ☐ Vomiting
- ☐ Other:

If other, specify:

14. If Jaw concerns:

- ☐ Clicking
- ☐ Popping
- ☐ Discomfort
- ☐ Limited opening
- ☐ Other:

If other, specify:

15. If History of oral surgery:

☐ Extractions ☐ Implants ☐ TMJ surgery

☐ Other:

If other, specify:

_____

16. If History of tooth loss (apart from surgical extractions), please explain:

_____

_____

_____

_____

17. Do you wear:

☐ Bridges ☐ Dentures ☐ Partials

Do you have:

☐ Headaches ☐ Earaches ☐ Neck pain

Do you have:

☐ Bad breath ☐ Metallic taste ☐ Unpleasant taste

Do you wear contact lenses?

○ Yes ○ No

18. Have you had ever had a problem with local anesthetics for dental procedures?

○ Yes

○ No

19. If yes, please explain:

_____

_____

_____

_____

20. Do you have any concerns about caring for your teeth?

○ Yes

○ No

21. If yes, please explain:

_____

_____

_____

_____

22. Any other concerns about your dental health?

○ Yes

○ No

23. If yes, please explain:

24. Are you interested in whitening your teeth?
○ Yes ○ No

How often do you brush your teeth?

How often do you floss?

25. Do you have any anxiety about dental procedures?

○ Yes
○ No

26. If yes, please explain:

MEDICAL HISTORY

27. Do you have a persistent or bloody cough?
○ Yes ○ No

Do you have active tuberculosis?
○ Yes ○ No

Have you been exposed to someone with tuberculosis?
○ Yes ○ No

28. Do you have a serious medical condition that is being managed by a physician?

○ Yes
○ No

29. If yes, please explain:

30. Have you recently (past year) been hospitalized?

○ Yes
○ No

31. If yes, please explain:

32. Have you had an organ transplant?

- ○ Yes
- ○ No

33. If yes, please list organ(s):

	Organ
1	

34. Have you had open heart surgery?

- ○ Yes
- ○ No

35. If you have had open heart surgery:

Date:

Please specify type:
☐ Valve ☐ Bypass (CABG) ☐ Other:

If other, please specify:

Any complication within the past 2 years?
○ Yes ○ No

If yes, please explain:

36. Have you had an orthopedic joint replacement?

- ○ Yes
- ○ No

37. If you have had an orthopedic joint replacement:

Date:

Please indicate type:
☐ Ankle ☐ Hip ☐ Knee ☐ Shoulder ☐ Other:

If other, please specify:

Any complication within the past 2 years?
○ Yes ○ No

If yes, please explain:

38. Have you had radiation or chemotherapy for a medical condition?

- ○ Yes
- ○ No

39. If yes, please explain:

_____

_____

_____

_____

40. Have you taken steroid medication in the last 2 years?

- ○ Yes
- ○ No

41. Do you take (or have you taken) oral or IV bisphosphonate medications (Fosomax, Zometa, Actonel)?

- ○ Yes
- ○ No
- ○ Current

42. If yes, list:

	Medication	Length	Condition
1			
2			
3			

43. Have you taken any of the drugs called “fen-phen”?

- ○ Yes
- ○ No

44. How would you rate your overall health? _____ How would you rate your dental health? _____

Please indicate if you have any of the following medical conditions:

45. Cardiovascular

- ☐ Heart Disease
- ☐ Angina/Heart Attack
- ☐ Rheumatic fever
- ☐ Stroke/TIA
- ☐ Artificial heart valves
- ☐ Heart murmur
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Ankle swelling

46. Head, Ear/Nose/Throat

- ☐ Headaches
- ☐ Vision Problems
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Tonsillitis

47. Respiratory

- ☐ Asthma/COPD
- ☐ Bronchitis
- ☐ Breathing Difficulty
- ☐ Tuberculosis
- ☐ Chronic Sinusitis
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Persistent Cough
- ☐ Snoring

48. Musculoskeletal

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Lupus/SLE
- ☐ Gout

49. Gastrointestinal

- ☐ Irritable Bowel Syndrome
- ☐ Peptic Ulcer Disease
- ☐ Hepatitis/Liver Disease
- ☐ Heartburn/GERD

50. Endocrine

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypoglycemia
- ☐ Hypothyroid
- ☐ Hyperthyroid

51. Neurological

- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Dementia
- ☐ Seizures/Epilepsy
- ☐ Neuropathy
- ☐ Multiple Sclerosis
- ☐ Eating disorder
- ☐ Fainting/Dizziness

52. Genitourinary

- ☐ Kidney Stones
- ☐ Kidney Disease/Failure
- ☐ Prostatic problems
- ☐ Venereal disease

53. Hematological (specify in the box that appears, where requested)

- ☐ Anemia
- ☐ Bleeding Disorder (i.e. Hemophilia, specify type)
- ☐ Blood Transfusions

_____ _____ _____

- ☐ Leukemia
- ☐ Lymphoma
- ☐ HIV/AIDS

_____ _____ _____

- ☐ Autoimmune Disorder (i.e. Lupus, specify type)
- ☐ Cancer (specify type)
- ☐ Other: (specify)

_____ _____ _____

MEDICATIONS

54. List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Name	Dose	Frequency	Reason for Taking?
1				
2				
3				

ALLERGIES

55. Please indicate if you have any allergies:

- ☐ No Known Drug Allergies
- ☐ Aspirin
- ☐ Acrylic
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other:

If other, please specify:

_____

FEMALES

56. Are you pregnant?

○ Yes ○ No

If yes, how many weeks?

_____

Are you breastfeeding?

○ Yes ○ No

Are you using:

☐ Birth control pills ☐ Fertility drugs

☐ Hormonal replacement

ENVIRONMENT AND HEALTH

57. Do you use tobacco?

- ○ Yes
- ○ No

58. If you use tobacco:

Specify type:

☐ Smoking ☐ Snuff ☐ Chew ☐ Bidis

How much do you use?

_____

How often?

Are you interested in quitting tobacco use?
○ Yes ○ No

59. Do you drink alcohol?
○ Yes ○ No

If yes, how much?

If yes, how often?

Do you use recreational drugs?
○ Yes ○ No

If use recreational drugs, please list type with the approximate amount and frequency: