Patient Intake Form

FIRST NAME Mr / Mrs / Ms	LAST	DATE OF BIRTH Y /M /D
ADDRESS		
CITY/PROVINCE	EMAIL	POSTAL CODE
TELEPHONE RESIDENCE	CELL	WORK
EMERGENCY CONTACT		

How did you hear about us: □ Google □ Walking through the mall □ An existing patient □ Other _____

Your answers are for our records only and will be confidential except where disclosure is required by law.

MEDICAL QUESTIONS:

1. Have there been any changes in your health in the past year? Y N
2. Are you under the care of a physician? Y N
3. Have you had any serious illnesses or operations? Y N
4. Females: Are you pregnant? Y N

   Explain any 'yes' answers: _____

   _____

5. **List any medications (prescription, non-prescription, and/or vitamins) you are currently taking:**

   _____

   _____

6. **Please check if you have (or have had) any of the following problems:**

□ AIDS / HIV Positive	□ Hearing loss	□ Shingles
□ Anemia	□ Heart murmur	□ Shortness of breath
□ Arthritis	□ Heart, any problems	□ Sinus problems
□ Artificial heart valve(s)	Describe_____	□ Skin rash
□ Artificial joint(s)	□ Hemophilia	□ Stroke
□ Asthma	□ Herpes	□ Surgical implants
□ Back problems	□ Hepatitis A B C D	□ Swelling, feet or ankles
□ Bleeding disorders	□ High blood pressure	□ Thyroid problems
□ Blood disease	□ Jaundice	□ Tuberculosis
□ Cancer	□ Jaw pain	□ Ulcers/colitis/acid reflex
Describe_____	□ Kidney disease	□ Vision Impairment
□ Chemo/radiation therapy	□ Liver disease	□ Other
□ Circulation problems	□ Low blood pressure	Describe_____
□ Cortisone treatments	□ Mitral valve prolapse	
□ Cough, persistent or bloody	□ Nervous problems	_____
□ Diabetes	□ Osteoporosis	
□ Emphysema	□ Pacemaker	□ **NONE OF THESE**
□ Epilepsy	□ Psychiatric care	
□ Food allergies	□ Respiratory disease	
□ Headaches, frequent/severe	□ Seizure disorders	

7. **Please check if you have any of the following Allergies/Sensitivities:**

□ Anesthetic	□ Iodine
□ Aspirin	□ Latex
□ Penicillin	□ Nickel
□ Codeine	□ Other_____
□ Sulfa	□ **NONE OF THESE**

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8. Pre-medication required before dental treatment? Y N

Prescribing Physician_____Dosage/Time Taken_____

9. Do you smoke or use any recreational drugs? Y N

Please explain: _____

DENTAL QUESTIONS:

What is your reason for attending our clinic today: _____

When was your last dental visit: _____

Please circle the appropriate answer for each condition/disease.

1. Have you had any serious problem(s) with any previous dental treatment? **Y N**
2. Have you ever had an injury to your face, jaw, or teeth? **Y N**
3. Do you ever feel like you have a dry mouth? **Y N**
4. Have you ever had an unusual reaction to local anesthetic (numbing)? **Y N**
5. Have you ever had any of the following treatment(s)? **Y N**

- □ Gum/periodontal treatment
- □ Orthodontics (braces)
- □ Endodontics (root canal)
- □ Extractions (teeth removed)
- □ Bleaching/whitening
- □ Dental Implants

Explain any yes answers: _____

_____

The answers to the questions listed above are accurate. I understand this information will be used to determine the dental treatment I receive in this dental office and may be shared with other medical offices only as necessary. I will notify this dental office should any information change. I hereby authorize this dental office to perform recommended services.

CONSENT FOR ELECTRONICALLY SUBMITTED CLAIMS & CONSENT FOR TREATMENT

I hereby assign my benefits, payable from claims submitted electronically, to The Dental Group at Central City. I authorize payment directly to him/her and permission through the "Privacy Act" to submit information via EDI or email to insurance, or to patient directly. This authorization shall continue in effect until undersigned revolves the same. I will assume responsibility for fees associated with these dental procedures. I am aware that it for any reason the insurance company does not pay the full amount for treatment rendered, I am responsible for the balance.

I authorize for the above-named MINOR consent for any dental x-rays deemed advisable by the Dentist. □ **YES** □ **NO**

Date _____ Signature _____

□ Patient □ Parent □ Guardian