SOUTHWEST DENTAL

# New Patient Dental Intake Form

## 1. Patient Information

Name: Preferred Name:

Address: City: State: Zip:

Birthdate: Email:

Cell Phone #: Alt. Phone #:

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other

Spouse/ Partner/ Parent Name: Phone #:

Emergency Contact (if different than above): Phone #:

Employer/School: Phone #:

Are you responsible for your account & payments? ☐ Yes ☐ No → If no, please answer below:

Name: Birthdate:

Address: City: State: Zip:

Phone #: Email:

How did you learn about us / whom may we thank for referring you?

## 2. Dental Insurance

Insurance Company:

**Member ID:** Group Number:

**Subscriber's SSN:** Employer:

Are you the main subscriber? ☐ Yes ☐ No → If no, please answer below:

Subscriber Name: Subscriber Birthdate:

**Secondary Insurance**:

Insurance Company:

**Member ID:** Group Number:

**Subscriber's SSN:** Employer:

Are you the main subscriber? ☐ Yes ☐ No → If no, please answer below:

Subscriber Name: Subscriber Birthdate:

## 3. Dental History

How often do you brush? How often do you floss?

Date of last dental visit: Date of last X-rays:

Name of former dentist:

Reason for today's visit:

**Check if you have any problems with the following:**

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking/popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth/broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity: ☐ Cold ☐ Hot ☐ Sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Other:

**4. Medical History**

Physician: Date of last visit:

Pharmacy: Location:

Have you had any serious illnesses or operations? ☐ Yes ☐ No Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please describe:

**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
- ☐ Artificial heart valves
- ☐ Artificial joints/pins
- ☐ 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/ankles
- ☐ Thyroid problems
- ☐ Hyperthyroidism
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other:

Have you ever taken any of the drugs referred to as "Fen-Phen"? ☐ Yes ☐ No

**Please list medications you are taking, any allergies, and the correlating diagnoses:**

| **Medication:** | **Diagnosis:** |
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| **Allergy:** | **Diagnosis:** |
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**5. Acknowledgement**

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/Guardian Signature:** Date: