Saddle Rock Dental

# Patient Intake Form

## Patient Information

Patient name: _____

Date of birth: _____

Address: _____

Cell phone: _____

E-mail: _____

Gender: ___Male ___Female ___Other

Employer or School: _____

Approximate height and weight: _____

Preferred Name or Nickname: _____

How did you find out about us? _____

## Emergency Contact

Name: _____ Phone: _____ Relationship: _____

## Dental Insurance Information

Primary Dental Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Subscriber ID #: _____

Group #: _____

Do you have ***secondary*** dental insurance? Yes / No *If YES, please list secondary dental insurance information below

Secondary Dental Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Subscriber ID #: _____

Group # : _____

## Medical History/Information

*Please circle yes or no for the following:*

Do you require **PREMEDICATION** prior to dental cleanings or dental treatment? YES / NO

Have you had recent exposure to any communicable infectious diseases? (Measles, Chicken pox, 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

Are you currently under the care of a healthcare professional for any kind of specific condition or syndrome? YES / NO

**WOMEN ONLY:** Are you pregnant, nursing or a possibility you could be pregnant? YES / NO

Have you ever had any major surgeries (heart, back, knee)? If so, when? _____

Do you have any known allergies? _____

**PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING ANY BLOOD THINNERS:**

_____

## Dental Information

Are you having any dental problems that require immediate attention? _____

When was your 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? _____

Do you clench or grind your teeth? _____

Have you ever had orthodontic treatment? (Braces or Invisalign) _____

Have you ever considered straightening, whitening or veneers? _____

Is there anything else you wish to share about your teeth? _____

**Please check any of the following that you have an allergy to or have had a bad reaction to:**

- ☐ Latex
- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Ibuprofen
- ☐ Insulin
- ☐ Iodine
- ☐ Barbiturates
- ☐ Doxycycline
- ☐ Amoxicillin
- ☐ Metals
- ☐ Codeine
- ☐ Other _____

**Please check any of the following that apply to you (current and past):**

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Artificial Heart Valve(s)
- ☐ Heart Surgery
- ☐ Heart Stent(s)
- ☐ Stroke
- ☐ Blood clots
- ☐ Bleeds easily
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ Asthma
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart Murmur
- ☐ HIV
- ☐ Epilepsy
- ☐ Hearing Impaired
- ☐ Seizures
- ☐ Smoker
- ☐ Drug/Alcohol Dependency
- ☐ Hepatitis
- ☐ Thyroid problems
- ☐ Mental Illness
- ☐ Dental anxiety
- ☐ Back surgery
- ☐ Neck surgery
- ☐ Chemotherapy/Radiation
- ☐ Emphysema
- ☐ Eye disorders
- ☐ Respiratory Problems
- ☐ Vertigo
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Chest Pain
- ☐ Hay Fever
- ☐ Replacement Joints
- ☐ Cancer
- ☐ Tumors
- ☐ Autism

**If you answered *YES* to cancer, chemotherapy, replacement joints or back/neck/heart surgery please explain below:**

_____

***I certify that the medical and dental information I have provided is correct to the best of my knowledge. I understand that it is my responsibility to inform Saddle Rock Dental of any changes to my personal information.**

**Patient Name (Print):** _____

**Patient Name (Sign):** _____

**Date:** _____