Doctorsinternet
Helping Local Patients Find You

Business Name
123 Main St, Anytown, USA 12345
(555) 555-5555
contact@business.com

Patient Intake Form

Email Address

Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Information

First Name

Last Name

Middle Initial

Home Phone

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Cell Phone

Work Phone

Preferred Method of Contact

- Phone
- Text
- Email

Mailing Address

City

State

Zip

Height

Weight

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Date of Birth

Sex

Occupation

Emergency Contact

How did you hear about us?

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

Home Phone

Cell Phone

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Dental Information

Are your teeth sensitive to cold, hot, sweets or pressure?

- Yes
- No

Does food or floss catch between your teeth?

- Yes
- No

Is your mouth dry?

- Yes
- No

Have you had any periodontal (gum) treatments?

- Yes
- No

Have you ever had orthodontic (braces) treatment?

- Yes
- No

Have you ever had any problems associated with previous dental treatment?

- Yes
- No

Is your home water supply fluoridated?

- Yes
- No

Do you drink bottled or filtered water?

- Yes
- No

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If yes, how often?

- Daily
- Weekly
- Occasionally

Do you have earaches or neck pains?

- Yes
- No

Do you have any clicking, popping, or discomfort in the jaw?

- Yes
- No

Do you brux or grind your teeth?

- Yes
- No

Do you have sores or ulcers in your mouth?

- Yes
- No

Do you wear dentures or partials?

- Yes
- No

Do you participate in active recreational activities?

- Yes
- No

Have you ever had a serious injury to your head or mouth?

- Yes
- No

Are you currently experiencing dental pain or discomfort?

- Yes
- No

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Chief Complaint

Date of your last dental exam

What was done at that time?

Date of last dental x-rays

Reason for visit

Medical Information

Are you currently under the care of a physician?

- Yes
- No

Physician Name

Phone Number

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Address / City / State / Zip

Are you in good health?

- Yes
- No

Has there been any change in your general health within the past year?

- Yes
- No

If yes, what condition is being treated?

Date of last physical exam

Do you have a history of chemical dependency?

- Yes
- No

Are you in recovery?

- Yes
- No

If yes, how long have you been in recovery?

Do you use controlled substances (drugs)?

- Yes
- No

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Do you use tobacco (smoking, snuff, chew, bidis)?

- Yes
- No

If so, how interested are you in stopping?

- Very
- Somewhat
- Not Interested

Do you drink alcoholic beverages?

- Yes
- No

If yes, how much alcohol did you drink in the last 24 hours?

Have you had a serious illness, operation or been hospitalized in the past 5 years?

- Yes
- No

If yes, what was the illness or problem?

Do you take any blood thinners?

- Yes
- No

Do you take aspirin on a regular basis?

- Yes
- No

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Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?

- Yes
- No

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

- Yes
- No

If yes, please list all medications, including vitamins, natural or herbal preparations and/or diet supplements

Women Only Are you:

Pregnant?

- Yes
- No

Number of weeks

Taking birth control pills or hormonal replacements?

- Yes
- No

Nursing?

- Yes
- No

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Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement?

- Yes
- No

If yes, date

If yes, have you had any complications?

Allergies Please mark "Yes" if you are allergic to (or have had a reaction to) the following.

Local anesthetics

- Yes
- No

Aspirin

- Yes
- No

Penicillin or other antibiotics

- Yes
- No

Barbiturates, sedatives, or sleeping pills

- Yes
- No

Sulfa drugs

- Yes
- No

Codeine or other narcotics

- Yes
- No

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Metals
- Yes
- No

Latex (rubber)
- Yes
- No

Iodine
- Yes
- No

Hay fever / seasonal
- Yes
- No

Animals
- Yes
- No

Food / Other
- Yes
- No

If yes, please specify

Please mark "Yes" if you have (or have had) any of the following diseases or problems.

Heart murmur
- Yes
- No

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Mitral valve prolapse
- Yes
- No

Artificial heart valves
- Yes
- No

Rheumatic fever
- Yes
- No

Cardiovascular disease
- Yes
- No

Angina
- Yes
- No

Arteriosclerosis
- Yes
- No

Congestive heart failure
- Yes
- No

Coronary artery disease
- Yes
- No

Damaged heart valves
- Yes
- No

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Heart attack
- Yes
- No

Low blood pressure
- Yes
- No

High blood pressure
- Yes
- No

Congenital heart defects
- Yes
- No

Pacemaker
- Yes
- No

Rheumatic heart disease
- Yes
- No

Abnormal bleeding
- Yes
- No

Anemia
- Yes
- No

Blood transfusion
- Yes
- No

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If yes, date

Hemophilia
- Yes
- No

AIDS or HIV infection
- Yes
- No

Arthritis
- Yes
- No

Autoimmune disease
- Yes
- No

Rheumatoid arthritis
- Yes
- No

Systematic lupus erythematosus
- Yes
- No

Asthma
- Yes
- No

Bronchitis
- Yes
- No

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Emphysema
- Yes
- No

Sinus trouble
- Yes
- No

Tuberculosis
- Yes
- No

Cancer / Chemotherapy / Radiation treatment
- Yes
- No

Chest pain upon exertion
- Yes
- No

Chronic pain
- Yes
- No

Diabetes type I or type II
- Yes
- No

Eating disorder
- Yes
- No

Malnutrition
- Yes
- No

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Gastrointestinal disease

- Yes
- No

GE Reflux / persistent heartburn

- Yes
- No

Ulcers

- Yes
- No

Thyroid problems

- Yes
- No

Stroke

- Yes
- No

Glaucoma

- Yes
- No

Hepatitis, jaundice, or liver disease

- Yes
- No

Epilepsy

- Yes
- No

Fainting spells or seizures

- Yes
- No

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Neurological disorders

- Yes
- No

If yes, please specify

Gag Reflex Sensitivity

- Yes
- No

Sleep disorder

- Yes
- No

Mental health disorders

- Yes
- No

If yes, please specify

Recurrent infections

- Yes
- No

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If yes, type of infection

Kidney problems

- Yes
- No

Night sweats

- Yes
- No

Osteoporosis

- Yes
- No

Persistent swollen glands in neck

- Yes
- No

Severe headaches / migraines

- Yes
- No

Severe / rapid weight loss

- Yes
- No

STDs / STIs

- Yes
- No

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Excessive urination

- Yes
- No

ADD

- Yes
- No

ADHD

- Yes
- No

Sensory Processing Disorder

- Yes
- No

Oral Sensory Sensitivity

- Yes
- No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

- Yes
- No

Do you have any disease, condition, or problem not listed above that you think we should know about?

- Yes
- No

If yes, please explain

Pharmacy Information

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Pharmacy Name

Pharmacy Phone

Pharmacy Address

Signature

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

- [ ] I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.