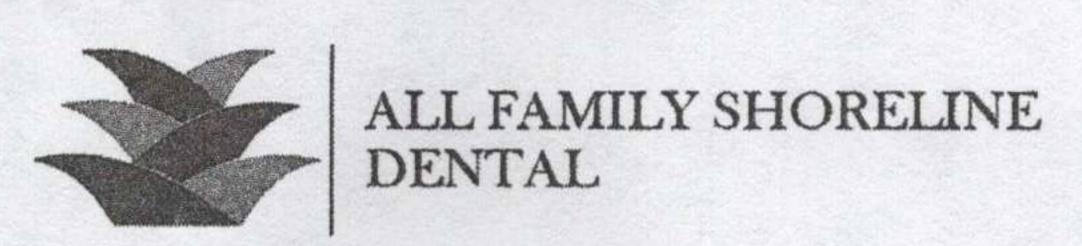


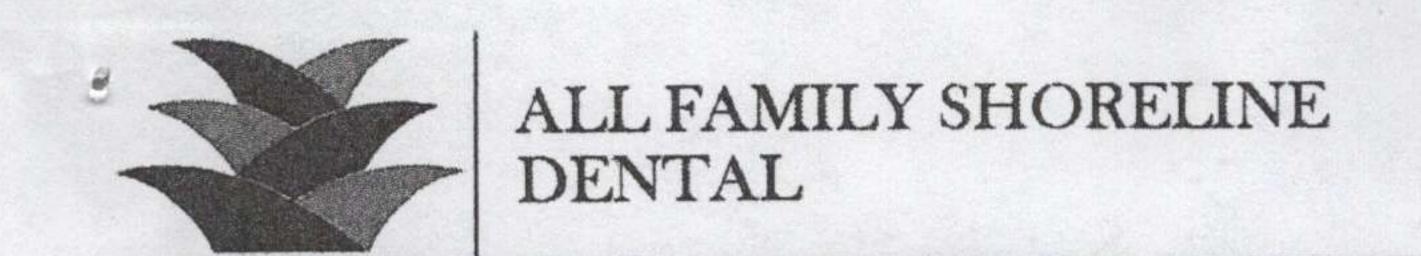
New Patient Dental Intake Form

Patient Information Name:		Birthdate:		
Address:	City:	State:	Zip:	
	ork phone:	Email:		
Sex: M F	Marital status: Single Marrie		d Partnership Widowed	
Employer or School:		Phone:		
Address:	City:	State:	Zip:	
Spouse, partner or parent name:				
Person to contact in case of an emergency:		Phone:		
How did you learn about our practice or whom ma	v we thank for referring you?			
Who is responsible for your account and payment's				
Address:	City:	State:	Zip:	
	mail:	Birthda		
Dental Insurance				
Insurance company:		Phone #	#	
Subscriber's Social Security #	Group #	ID#		
Address:	City:	State:	Zip:	
	nuch have you used? Wh	at is your annual maximum	n benefit?	
Whose name is this insurance under?				
Employer offering this insurance?		Phone:		
Address:	City:	State:	Zip:	
Secondary Dental Insurance				
Insurance company:		Phone	#	
Subscriber's Social Security #	Group #	ID #		
Address:	City:	State:	Zip:	
	much have you used? Wh	nat is your annual maximus	m benefit?	
Whose name is this insurance under?				
Employer offering this insurance?		Phone		
Address:	City:	State:	Zip:	
Dental History				
Reason for today's visit:				
Date of last dental care visit:	Date of	last dental x-rays:		
Former dentist's name:		Phone		
Check if you have any problem with the followin	g:			
Bad breath	Loose teeth or broken fillings			
Bleeding gums		Periodontal treatment		
Clicking or popping jaw	☐ Sensitivity	Sensitivity to any of the following: cold, hot, sweets		
Food collection between certain teeth	☐ Sensitivity	Sensitivity when biting		
Grinding teeth	☐ Sores or g	Sores or growth in your mouth		
How often do you floss?	How often do you	How often do you brush?		



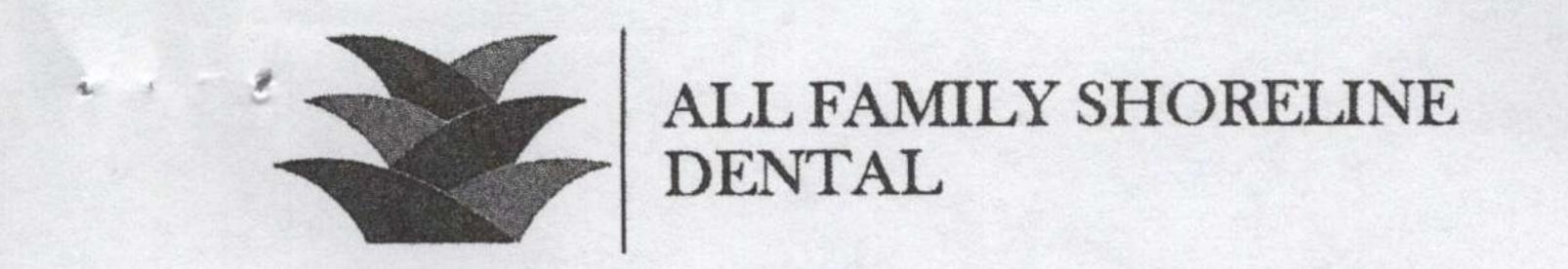
Medical History

Your physician:	Date of last visit:		
Have you ever taken any of the group	s of drugs collectively referred to as "fen-p	ohen"? Yes No	
Have you had any serious illnesses	or operations? Yes No		
If yes, describe:			
Have you ever had a blood transfusion	n? Yes No		
If yes, give approximate dates:			
Women: are you pregnant? Yes	□No		
Are you nursing? Yes No			
Are you taking birth control? [] Y	Yes No		
Check if you have or have had any of	the following:		
☐ Anemia	☐ Fainting	Radiation treatment	
Arthritis, rheumatism	Glaucoma	Respiratory disease	
Artificial heart valves	Headaches	Rheumatic fever	
Artificial joints, pins, etc.	Heart murmur	Scarlet fever	
Asthma	Heart problems	Sexually transmitted disease	
Bleeding abnormally	Hemophilia	Stroke	
Blood disease	Hepatitis	Swelling of feet or ankles	
☐ Cancer	High blood pressure	☐ Thyroid problems	
Chemical dependency	☐ HIV AIDS	☐ Tobacco use	
Chemotherapy	☐ Jaw pain	☐ Tonsillitis	
Circulatory problems	☐ Kidney disease	☐ Tuberculosis	
Congenital heart lesions	Liver disease	Ulcer	
☐ Diabetes	Mitral valve prolapse		
☐ Epilepsy	Pacemaker		
List medications you are currently	taking and the correlating diagnosis:		
Medication			
Please list any allergies vou may ha	ve:		
Allergy			
HOLD HOLD HOLD HOLD HOLD HOLD HOLD HOLD		inderstand that it is my responsibility to inform my	
doctor if I or my minor child has a ch	ange in health.		
Patient or Guardian Signature		Date	



TMJ Dysfunction Questionnaire

Name:		
1. Do you have a grating, clicking or popping	sound in either or both jaws when you chew?	Yes or No
2. Do you have sensations of stuffiness, pressure or blockage, ringing, hissing, or buzzing in your ears?		Yes or No
3. Do you ever feel dizzy or faint?		Yes or No
4. Is your jaw painful or locked when you wake up in the morning?		Yes or No
5. Do you consider yourself chronically fatigued?		Yes or No
6. Are you ever nauseated for no apparent reason?		Yes or No
7. Do your fingers sometimes go numb?		Yes or No
8. Check any area where you have pain or so	reness:	
☐ Jaw joints ☐ Upper jaw or teeth	Back of head	
☐ Forehead ☐ Lower jaw or teeth	Chewing muscles	
☐ Temples ☐ Side of neck	Behind the eyes	
☐ Tongue		
9. Is it hard to move your jaw side-to-side, for	rward or backward?	Yes or No
10. Do you have difficulty chewing?		Yes or No
11. Do you have back teeth missing?		Yes or No
12. Have you had extensive dental crowns and bridgework?		Yes or No
13. Do you clench your teeth during the day?		Yes or No
14. Do you grind your teeth at night? (Ask someone)		Yes or No
15. Do you ever have a headache when you wake up?		Yes or No
16. Have you ever had a whiplash injury?		Yes or No
17. Have you worn a cervical collar or had neck traction?		Yes or No
18. Have you ever had a blow to the chin, fac	e or head?	Yes or No
19. Have you reached the point at which drug	gs no longer relieve your symptoms?	Yes or No
20. Does chewing gum start up your sympton	ns?	Yes or No
21. Does your jaw deviate to the left or right when you open wide?		Yes or No



OFFICE POLICY

We must have a 48-hour cancellation notice on any appointment(s). We understand that situation arises, but please try to contact us during business hours to make any changes to your appointment(s). If there is more than 1 missed appointment without notice, a \$75 charge will be added to your account. We strive to provide quality service, so we ask that our patients understand our policy.

FINANCIAL POLICY

All payments are due at the time of service, unless prior arrangements have been made. Seniors over 65, without dental insurance, receive a 5% senior courtesy. We are in-network with most PPO plans, and are happy to submit to your insurance(s) on your behalf. However, copays are due at the time of service, unless prior arrangements are made. If we are billing to your insurance, please understand that this is a courtesy, it is your responsibility to research the coverage and limitations of your dental insurance. If you have any questions or concerns, please feel free to contact our office. We will do our best to maximize your insurance plans.

I have read and understand the office and financial policy. I understand that I am ultimately responsible for services rendered in the office.

Patient or Guardian Signature	Date	