ALL FAMILY SHORELINE
DENTAL

New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Email: _____

Sex: ☐ M ☐ F Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ 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 may we thank for referring you? _____

Who is responsible for your account and payment? (if different from previous listing): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Birthdate: _____

Dental Insurance

Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum 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: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum 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 following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between certain teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to any of the following: cold, hot, sweets
☐ Sensitivity when biting
☐ Sores or growth in your mouth

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

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Medical History

Your physician: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates: _____

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, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ 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 or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	

Please list any allergies you may have:

Allergy	

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 or Guardian Signature *Date*

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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 soreness:

☐ 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, forward 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, face or head? Yes or No
19. Have you reached the point at which drugs no longer relieve your symptoms? Yes or No
20. Does chewing gum start up your symptoms? Yes or No
21. Does your jaw deviate to the left or right when you open wide? Yes or No

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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*