Illiana Endodontics, Inc.

NEW DENTAL PATIENT INTAKE FORM

Patient Information

Name:_____ DOB:_____ SS#:_____

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

Home Phone:_____ Cell Phone:_____ Email:_____

Sex: __M __F Marital Status: __Single __Married __Divorced __Separated __Widowed

Employer or School:_____

Spouse, Partner or Parent Name:_____

Person to contact in case of emergency:_____ Phone:_____

How did you hear about our practice or whom may we thank for referring you?_____

Who is responsible for your account and payment (if minor)?_____

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

Phone:_____ Birthdate:_____ SS#:_____

Dental Insurance

Insurance Company:_____

Phone:_____

Subscriber or SS#:_____

Group#:_____

Whose name is the insurance under?_____

DOB:_____

Employer:_____

Secondary Dental Insurance

Insurance Company:_____

Phone:_____

Subscriber or SS#:_____

Group#:_____

Whose name is the insurance under?_____

DOB:_____

Employer:_____

Dental History

Who is your dentist:_____ Patient for how long:_____

Any important findings:_____

Who is your physician:_____ Phone #:_____

May we request your health/dental records if necessary: __Yes __No Are you in any discomfort at the present time: __Yes __No

Check if you have or have had any of the following:

__AIDS/HIV
__Alzheimer's
__Anemia
__Angina
__Anaphylaxis
__Anxiety
__Any immune deficiency
__Any type of implant
__Any type of transplant
__Arthritis, rheumatism
__Artificial heart valves
__Artificial joints, pins, etc
__Asthma
__Back problems
__Bleeding gums
__Blood disease
__Breathing problems
__Bulimia
__Cancer
__Cardiovascular disease
__Chest pain
__Chemotherapy
__Circulatory problems
__Convulsions
__Currently pregnant
__Diabetes
__Difficulty chewing
__Difficulty opening jaw
__Drug addiction
__Ear aches
__Epilepsy/seizures
__Excessive thirst
__Fainting/dizzy spells
__Frequent cough
__G.E. reflux/heartburn
__Head/neck injury
__Headaches
__Heart attack/failure
__Heart surgery
__Heart trouble
__Heart rhythm disorder
__Hepatitis A
__Hepatitis B
__Hepatitis C
__High blood pressure
__HPV
__Jaw pain or clicking
__Lip/cheek biting
__Loose teeth
__Low blood pressure
__Mitral valve prolapsed
__Neurological disorders
__Osteoporosis
__Pacemaker
__Pain around ear
__Periodontal disease
__Recurrent infections
__Respiratory problems
__Rheumatic fever
__Scarlet fever
__Shingles
__Sinus problems
__Sleep apnea
__Slow healing wounds
__Stomach problems
__Stroke
__Teeth grinding/clenching
__Thyroid disease
__Tooth pain/sensitivity
__Tuberculosis(TB)
__Tumors/Growths
__Ulcers
__Use of controlled substances
__Use of tobacco
__Other_____

Have you ever had endodontic treatment (root canal): __Yes __No

Medications you are currently taking:_____

Are you allergic to any medications:_____

Signature_____ Date_____