NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name	Test Patient	**Date of birth**	1975-10-16

Address 1234 Street Haiku, HI 96708 Canada	**Phone** 555-123-4567 **Email** testpatient@outlook.com

Do you have dental insurance? No

PRIMARY INSURER

Insurance company name

Certificate / ID number	**Group / policy number**	**Are you a dependant?**
Name of insurer	**Insurer date of birth**	**Relationship**

SECONDARY INSURER

Insurance company name

Certificate / ID number	**Group / policy number**	**Are you a dependant?**
Name of insurer	**Insurer date of birth**	**Relationship**

How did you hear about our clinic?
Referral

MEDICAL HISTORY

Do you have a family physician? No

Name	**Phone**

Do you have a dentist? No

Name	**Phone**

Do you experience any dry mouth with or without medication? No

Have you ever had any head, facial, jaw or neck trauma? No

Do any of the following conditions apply to you?

- ☐ Facial muscle tenderness
- ☐ Earaches
- ☐ Hearing issues
- ☐ Sore or tender gums
- ☐ Joint clicking, popping or locking
- ☐ TMJ (Jaw) pain
- ☐ Lumps or sores in your mouth now
- ☐ Do you snore a lot
- ☐ Migraines or headaches
- ☐ Neck or shoulder pain
- ☐ Do you grind your teeth
- ☐ Burning sensation on your lips or tongue
- ☐ Do you gasp or stop breathing in your sleep

Additional condition details

Do you smoke?
No

Are you allergic to the following?

- ☐ Latex
- ☐ Metal
- ☐ Acrylic
- ☐ Other

Please specify allergy

Have you ever had or are going through radiation or chemotherapy? No	**When did you last go through radiation or chemotheraphy?**

Do you have hearing or memory issues where you may need extra assistance? No

Do you have any of the following serious illnesses?

- ☐ Heart condition
- ☐ Cold sores
- ☐ Tuberculosis
- ☐ Asthma
- ☐ High blood pressure
- ☐ Mouth cancer
- ☐ Diabetes
- ☐ Sinus trouble
- ☐ Hepatitus A/B/C
- ☐ HIV or AIDS
- ☐ Stroke
- ☐ Snoring
- ☐ Drug addiction
- ☐ Epilepsy or seizures
- ☐ Jaundice

If you have a serious illness that is not listed, please list
N/A

Is there anything else the denturists should know about your health?

DENTURE HISTORY

Do you have a complete denture?

☐ Upper denture ☐ Lower denture ☒ None

Upper denture: Age	**Upper Denture: Last Reline**
Lower denture: Age	**Lower Denture: Last Reline**

Do you have partial dentures?

☐ Upper denture ☐ Lower denture ☒ None

Upper denture: Age	**Lower denture: Age**

Do you have implants?
No

Do you have any natural teeth remaining?

☐ Upper ☐ Lower ☒ None

When was the last time you have seen a dentist? 1 to 2 years	**Do you know if you need any dental work done?** Not Sure

Are you happy with your current dentures?
No

What are your concerns with your current dentures?
Irritation

What is your goal with your dentures?
Comfort

CONSENT

✔ I, the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my Dentist, previous Denturist or Physician being contacted if necessary, as further dental/medical information may be required for my dental care. I, the undersigned, hereby consent to the performing of the preventative dental procedures. I, the undersigned, am aware that the whole amount of treatment is due to be paid by me and understand any direct billing to my insurance plan that comes back unpaid is to be paid promptly by me.

Patient signature