NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name	John Smith	**Date of birth**	12/08/2020

Address 1234 Main Street Mountain Street, PEI JJJ666 Canada	**Phone** 222-333-8888 **Email** ildikopap@yahoo.ca

Do you have dental insurance?	Yes

PRIMARY INSURER

Insurance company name
SunLife

Certificate / ID number	**Group / policy number**	**Are you a dependant?**
123456	12	Yes
Name of insurer	**Insurer date of birth**	**Relationship**
Joanna Smith	12/29/2020	Parent / Guardian

SECONDARY INSURER

Insurance company name
SunLife

Certificate / ID number	**Group / policy number**	**Are you a dependant?**
564789	23	No
Name of insurer	**Insurer date of birth**	**Relationship**

How did you hear about our clinic?
Sign

MEDICAL HISTORY

Do you have a family physician?	Yes

Name	John	**Phone**	Smith

Do you have a dentist?	Yes

Name	Joan	**Phone**	Smith

Do you experience any dry mouth with or without medication?	Yes
Have you ever had any head, facial, jaw or neck trauma?	Yes

Do any of the following conditions apply to you?

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

Additional condition details
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Do you smoke?
Yes

Are you allergic to the following?

- [x] Latex
- [ ] Metal
- [ ] Acrylic
- [x] Other

Please specify allergy
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Have you ever had or are going through radiation or chemotherapy?	**When did you last go through radiation or chemotheraphy?**
Yes	12/24/2020

Do you have hearing or memory issues where you may need extra assistance?	Yes

Do you have any of the following serious illnesses?

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

If you have a serious illness that is not listed, please list
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Is there anything else the denturists should know about your health?
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DENTURE HISTORY

Do you have a complete denture?

- [X] Upper denture
- [ ] Lower denture
- [ ] None

Upper denture: Age	**Upper Denture: Last Reline**
10 or more years	5 to 10 years
Lower denture: Age	**Lower Denture: Last Reline**

Do you have partial dentures?

- [ ] Upper denture
- [X] Lower denture
- [ ] None

Upper denture: Age	**Lower denture: Age**
	1 to 5 years

Do you have implants?
Yes

Do you have any natural teeth remaining?

- [X] Upper
- [ ] Lower
- [ ] None

When was the last time you have seen a dentist?	**Do you know if you need any dental work done?**
6 months to 1 year	Yes

Are you happy with your current dentures?
Somewhat

What are your concerns with your current dentures?
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What is your goal with your dentures?
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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