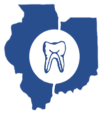

Illiana Endodontics, Inc.

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

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

Medications you are currently taking:____________________

____

____

Are you allergic to any medications:____________________

____

____

Signature____________________ Date__________