

PATIENT INTAKE FORM

Welcome to our practice! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for you/your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

PATIENT INFORMATION

Patient's Name: _____ Male Female

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

Home Phone: _____ Work Phone: _____ Email: _____

Preferred Name: _____ Date of Birth (mm/dd/yyyy): _____

DENTAL HISTORY

Previous Dentist: _____ City: _____ Office Phone #: _____

Date of Last Exam: _____ Last Cleaning: _____ Last X-rays: _____

Please check all that apply:

Had previous orthodontic care: Yes No

Name of Orthodontist: _____

When: _____

Pain with the teeth, mouth, or jaws: Yes No

Speech Problems: Yes No

Suffered any injuries to teeth or jaw: Yes No

Breathe mostly through the mouth: Yes No

Play a musical instrument that touches lips: Yes No

Have a parent who had braces: Yes No

Suck thumb, fingers or pacifier: Yes No

Have habits that cause orthodontic problems: Yes No

Have any other habits or concern: Yes No

Please describe: _____

What kind of water does the patient drink? City Water Well Water Bottled Water Other: _____

Has patient ever had complications following dental treatment? Yes No If Yes, please describe: _____

Does patient have to be pre-medicated with an antibiotic prior to receiving dental care? Yes No

MEDICAL HISTORY

Physician's Name: _____ City: _____ Date of last physical: _____

Office Phone #: _____ Pharmacy: _____ Phone #: _____

What do you rate this patient's overall health? Excellent Good Fair Poor Immunization current? Yes No

Please check YES or NO to indicate if patient has, has had, or has been diagnosed with any of the following:

AIDS/HIV Yes No

Hepatitis Type Yes No

Prone to ear infections Yes No

Anemia Yes No

Hernia Repair Yes No

Prone to sore throats Yes No

Asthma Yes No

Kidney Disorder Yes No

Psychiatric Care Yes No

Bone Disorder Yes No

Latex Allergy Yes No

Rheumatic Fever Yes No

Diabetes type Yes No

Latex Sensitive Yes No

Seizures Yes No

Dizziness or Fainting Yes No

Liver Disorder Yes No

Sinus Trouble Yes No

Endocrine Yes No

Mitral Valve Prolapse Yes No

Tonsils and/or adenoids removed Yes No

Facial/Jaw/TMJ Pain Yes No

Hearing Impaired Yes No

Trauma to face or jaw Yes No

Nervous Disorders Yes No

Tuberculosis Yes No

Heart Condition Yes No

Prolonged Bleeding Yes No

Ulcer Yes No

Heart Murmur Yes No

Prone to colds Yes No

Vision Impaired Yes No

Other medical condition not listed above: _____

Medications: _____

Allergies: _____

Has patient ever been hospitalized? YES NO If YES, please describe: _____

FEMALE ONLY

Is patient on any type of prescribed birth control? YES NO If YES, please specify: _____ Age of first menses: _____

Is patient pregnant YES NO If YES, what is the due date: _____ Is patient nursing? YES NO

By signing below, I certify that the information provided above is accurate and true to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____

Patient's Name: _____ Birth Date: _____

Reason for today's visit: Routine Check-up Evaluation of specific concern: _____

REFERRAL SOURCE

How did you hear about our practice? Internet, website: _____

Doctor name: _____ Patient Name: _____

Insurance Company: _____ Other: _____

RESPONSIBLE PARTIES

Patient lives with: Father Mother Legal Guardian For Legal Guardians, can you provide legal documentation? Yes No

Father: _____ Mother: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Years at address: _____ Own/Rent: _____ Years at address: _____ Own/Rent: _____

Source of Income: _____ Occupation: _____ Source of Income: _____ Occupation: _____

Employer: _____ Years employed _____ Employer: _____ Years employed _____

Home phone #: () _____ Home phone #: () _____

Work phone #: () _____ Work phone #: () _____

Email: _____ Email: _____

Other than the persons named above, are there other individuals authorized to make treatment/financial decisions for this patient? Yes No

Name/Relationship to patient: _____ Name/ Relationship to patient: _____

INSURANCE INFORMATION

Insurance Company: _____ Insurance phone #: () _____

Insurance Address: _____

Policy Holder: _____ Relationship to Patient: _____

Policy #: _____ Social Security #: _____ Birth Date: _____

Employer/Group Name: _____ Group #: _____

EMERGENCY CONTACTS

Name: _____ Phone #: () _____ Relationship to Patient: _____

Name: _____ Phone #: () _____ Relationship to Patient: _____

PATIENT PHOTO DISPLAYING CONSENT

If this patient presents no cavities at routine check-up visits, may we display his/her photo on our No Cavity Club board? Yes No

ACKNOWLEDGEMENT

By signing below, I certify that the information provided above is accurate and to the best of my knowledge. In the event that there is any issue regarding custody of a minor patient, I understand that Larry J. Moray, DDS, MS, PA and Associates must be provided with court-sanctioned custody papers that clearly describe custody arrangements and designates one individual who is authorized to consent treatment and who is financially responsible for incurred charges. Larry J. Moray, DDS, MS, PA and Associates reserve the right to defer or refuse treatment. I understand that, where appropriate credit bureau reports may be obtained. I also acknowledge that I have received, read and understood the practice's Office Policies and Financial Policies.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____