Quail Ridge DENTAL

Patient Intake Form

Personal Information

Name: _____

Birthdate (DD/MM/YYYY): _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____ P/Code: _____

Email Address: _____

Parent's Name: _____

Emergency Contact

Name: _____

Phone: _____

Employer: _____

Care Card Number: _____

Recommended By: _____

Would you like to be signed up for automatic appointment reminders? ☐ Yes ☐ No

If yes, ☐ Text ☐ Email

Dental History

Do you have any dental problems at present? ☐ Yes ☐ No

If yes, please specify: _____

When was your last dental visit? _____

Do you visit the dentist regulary? ☐ Yes ☐ No If yes, how often? _____

Name of previous dentist/office? _____

Do you have any habits such as clenching/grinding your teeth, nail biting or thumb/finger sucking? _____

How would you rate your smile? _____

What if anything would you change about your smile? _____

Are you interested in teeth whitening? ☐ Yes ☐ No

Are you interested in Botox for cosmetic or therapeutic use? ☐ Yes ☐ No

What type of toothbrush (manual/electric), mouthwash and floss do you use? _____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE, OUR OFFICE WILL BE PLEASED TO PROCESS YOUR DENTAL INSURANCE CLAIMS ON YOUR BEHALF, AND IT IS THE RESPONSIBILITY OF THE INSURED TO PAY ANY CHARGES NOT PAID BY THE INSURANCE COMPANY.

_____ _____

Date Patient or Parent/Guardian Signature

Medical History

Your Current Physician

Name: _____ Phone number: _____

Have you had a medical exam in the past year? _____

Are you being treated for any condition by a physician? ☐ Yes ☐ No

If yes, what: _____

Have you ever reacted adversely to any of the following?

☐ Aspirin	☐ Barbiturates	☐ Sulfa drugs	☐ Fluoride
☐ Penicillin	☐ Fluoride	☐ Latex	☐ Acetaminophen
☐ Iodine	☐ Codeine	☐ Ibuprofen	☐ Local Anaethetic

Do you have any other allergies? ☐ Yes ☐ No Please list: _____

Have you ever had or do you have any of the following diseases or conditions?
If applicable, please list any medications and currently prescribed for the following.

☐ AIDS/HIV	☐ Diabetes	☐ Medical Device
☐ Adult Jaundice	☐ Epilepsy	☐ Radiation/Chemotherapy
☐ Anemia	☐ Heart Disease/Attack	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Pacemaker	☐ Stroke
☐ Artificial Heart Valve	☐ Hepatitis A B C	☐ Cold Sores or Canker Sores
☐ Artificial Joint (knee, hip, other) If yes, date: _____	☐ High/Low Blood Pressure	☐ Stomach/Insestinal Problems
☐ Asthma	☐ Kidney Disease	☐ TB/Lung Disease
☐ Blood Disorder	☐ Anxiety or Mental Illness	☐ Thyroid Disease (Hyper/Hypo)
☐ Cancer	☐ Mitral Valve Prolapse	☐ ADHD
☐ Cholesterol	☐ Organ Transplant	☐ Other Medication/Condition

Further details: _____

_____

Do you bruise or bleed abnormally? ☐ Yes ☐ No

Have you ever had any injury, surgery or radiation on your face or jaw? ☐ Yes ☐ No

Are you on any special diet? ☐ Yes ☐ No

Are there any genetically linked disorders in your family? ☐ Yes ☐ No

Do you currently have, or have had in the past, any disease, condition or problem not listed above? ☐ Yes ☐ No

If yes, please specify: _____

Do you smoke, vape, or chew tobacco? ☐ Yes ☐ No

Are you pregnant or suspect you may be? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No