CORNERSTONE
FAMILY DENTISTRY

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.

PERSONAL INFORMATION

Patient's Name: _____ □ Male □ Female

Date of Birth: _____ Drivers License #: _____ State: _____ SSN: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Where do you prefer to receive calls? □ Home □ Work □ Cell Email address: _____

When is the best time to reach you? Days _____ Time: _____

Employer: _____ Occupation: _____

Referred by: _____

In the event of an emergency, who do you want us to contact?

Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY (Fill out only if different than patient)

Name of person responsible for scheduling and billing: _____ Relationship: _____

Date of Birth: _____ Drivers License #: _____ State: _____ SSN: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Name of insured: _____ Relationship to patient: _____

Date of Birth: _____ Social Security No.: _____

Name of Employer: _____ Employer Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Member ID: _____ Group #: _____

Ins. Co. Mailing Address: _____

Ins. Co. Phone #: _____

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 When: _____ Name of Orthodontist:_____
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 PATIENTS

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

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

ACKNOWLEDGEMENT

As a courtesy to our patients, we utilize an automated system to send reminders about your appointment via text or telephone call. Text message rates may apply from your mobile carrier, subject to the terms and conditions of your mobile carrier. Please notify us if you do not want to receive text messages.

Print Name:_____**Relationship to Patient:**_____

Signature:_____**Date:**_____