EdgeDental
GENERAL DENTISTRY
COSMETIC & ESTHETIC
NEUROMUSCULAR

PATIENT INTAKE FORM

DATE: / /

PATIENT INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Dr.

FIRST NAME:

M.I:

LAST NAME:

SEX: ☐Male ☐Female

DATE OF BIRTH (D.O.B): AGE:

EMAIL:

STREET:

CITY: POSTAL CODE:

PROVINCE:

HOME TEL: ( )

CELL: ( )

MEDICAL DOCTOR: TEL:

EMPLOYER: BUS. TEL:

EMERGENCY CONTACT

NAME: TEL:

RELATION: ALT TEL:

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

NAME: TEL:

RELATION: ALT TEL:

INSURANCE INFORMATION

STUDENT: ☐Full-time ☐Part-time

SCHOOL NAME/ADDRESS:

STUDENT ID:

☐Married ☐Divorced ☐Legally Separated ☐Widow

EMPLOYMENT:
☐Full-time ☐Part-time ☐Retired ☐Not

PRIMARY DENTAL INSURANCE

EMPLOYER

BUS. ADDRESS:

BUS. TEL: PLAN

INS. CO. NAME:

ADDRESS:

TEL: ( )

GROUP NAME: NO:

INSURED PARTY: RELATION:

SEX: ☐Male ☐Female D.O.B.:

ADDRESS:

TEL: ( ) I.D.#

SECONDARY DENTAL INSURANCE

EMPLOYER

BUS. ADDRESS:

BUS. TEL: PLAN

INS. CO. NAME:

ADDRESS:

TEL: ( )

GROUP NAME: NO:

INSURED PARTY: RELATION:

SEX: ☐Male ☐Female D.O.B.:

ADDRESS:

TEL: ( ) I.D.#

PATIENT INTAKE FORM

HEALTH HISTORY

Please indicate all health issues and medications that you are taking as this will help to alert our doctors and allow for the provision of safe dental treatment. All answers are confidential and for our records only.	YES	NO
Are you in good health? HEIGHT: WEIGHT:	☐	☐
Have there been any changes in your general health in the past year?	☐	☐
Are you under the care of a physician? *If so, what are you being treated for:* Date of last visit: / /	☐	☐
Have you had any illness, operation or been hospitalized in the past five years? *If so, please describe:*	☐	☐
Do you have unhealed injuries/ inflamed areas/ growths or sore spots in or around your mouth? *If so, please describe where:*	☐	☐
Do you have a prosthetic joint/ implant? If so, describe where	☐	☐
Have you had a heart valve replacement or vascular graft?	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO
Rheumatic fever	☐	☐
Damaged heart valves/mitral valve prolapse	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chest pain/ angina	☐	☐
Heart attack(s)	☐	☐
Irregular heart beat	☐	☐
Cardiac pacemaker	☐	☐
Heart surgery	☐	☐
Bronchitis, chronic cough	☐	☐
Asthma	☐	☐
Hay fever/ sinus problems	☐	☐
Snoring/ sleep apnea	☐	☐
Difficulty breathing/ other lung trouble	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Do you smoke?	☐	☐
Do you use chewing tobacco	☐	☐
Blood transfusion	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO
Blood disorder such as anemia	☐	☐
Bruise easily	☐	☐
Bleeding tendency/abnormal bleed	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Infectious mononucleosis	☐	☐
Gallbladder trouble	☐	☐
Fainting spells	☐	☐
Convulsions/epilepsy	☐	☐
Stroke	☐	☐
Thyroid trouble	☐	☐
Diabetes	☐	☐
Low blood sugar	☐	☐
Kidney trouble	☐	☐
Are you on dialysis?	☐	☐
Swollen ankles, arthritis or joint disease	☐	☐
Stomach ulcers	☐	☐
Contagious diseases	☐	☐
HIV/AIDS	☐	☐
Sexually transmitted diseases	☐	☐
Problems with the immune system	☐	☐

HEALTH HISTORY cont.

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO
Delay in healing	☐	☐
A tumor or growth	☐	☐
Radiation therapy/ chemotherapy	☐	☐
Chronic fatigue/ night sweats	☐	☐
Are you on a diet	☐	☐
History of drug abuse	☐	☐
History of alcohol abuse	☐	☐
Contact lenses	☐	☐
Eye disease/glaucoma	☐	☐
Mental health problems	☐	☐
A removable dental appliance	☐	☐
Pain and clicking of the jaws when eating	☐	☐
Malignant hyperthermia	☐	☐

DENTAL HISTORY	YES	NO
Are you currently in pain?	☐	☐
Do you experience stress or anxiety when you visit a dental office?	☐	☐
Have you ever experienced TMJ problems?	☐	☐
Do you grind your teeth at night?	☐	☐
Do you suffer from headaches?	☐	☐
Reason for today's visit:		
How did you find out about us? *If you referred to, please mention the referrer below:*		

Your current dental health is:	GOOD	FAIR	POOR
	☐	☐	☐

Approximate date of your last visit:

Previous dental x-rays were taken:

☐ Less than a year ago ☐ Longer than a year

ARE YOU CURRENTLY TAKING MEDICATIONS?	YES	NO
Any medications, drugs or pills	☐	☐
Blood thinners (Coumadin, Aspirin, Advil)	☐	☐
Have you ever taken diet pills	☐	☐
Tranquilizers	☐	☐
Any natural product, herbal supplement or homeopathic remedy	☐	☐

Please list any other medications you are taking:

WOMEN ONLY	YES	NO
Is there any possibility of pregnancy?	☐	☐
Expected delivery date	☐	☐
Are you nursing	☐	☐
Are you taking birth control pills	☐	☐

ARE YOU ALLERGIC TO OR HAD A REACTION TO ...	YES	NO
Local anesthetic	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Sulfa drugs	☐	☐
Sodium pentothal, valium or other tranquilizers	☐	☐
Aspirin	☐	☐
Codeine or other narcotics	☐	☐
Other medications	☐	☐
Latex	☐	☐
Soy	☐	☐
Eggs/yolk	☐	☐
Sulfites	☐	☐

Please list any other allergies:

PATIENT INTAKE FORM

CONSENT

I certify that I have read and understood the questions above and answered each one correctly to the best of my knowledge. I hereby authorize the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

I understand that full payment is due at the time of service unless other arrangements have been made prior to the appointment.

If you have dental insurance coverage, we will be happy to assist you in the filing of your claims for reimbursement. The insurance company will reimburse you directly.

Please keep in mind that some important services may not be covered by your plan. If you have any questions or concerns about your coverage, please contact your insurance company prior to your appointment.

PATIENT'S NAME:

PATIENT'S SIGNATURE: DATE: / /

PARENT/ RESPONSIBLE PARTY'S SIGNATURE: RELATIONSHIP TO PATIENT: