Date: _____

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other

Phone: _____ Email: _____

Address: _____

Referred By: _____ Previous Dentist: _____

CHIEF COMPLAINT

What is the main reason for your visit today? _____

_____

How long has this been an issue? _____

Severity (1–10): _____

Has it been: ☐ Getting Better ☐ Getting Worse ☐ Staying the Same

What triggers or improves it? _____

DO ANY OF THE FOLLOWING APPLY TO YOU?

☐ Pain when chewing
☐ Sensitivity to hot/cold
☐ Jaw clicking or locking
☐ Limited or difficult opening of mouth
☐ Bad breath
☐ Mouth sores / ulcers — Upper ☐ Lower ☐
☐ Dry mouth
☐ Loose teeth
☐ Diet limited to semisolid, soft, or liquid foods
☐ Numbness in lower lip or jawbone
☐ Tingling in jawbone
☐ Difficulty speaking

☐ Nutritional disorders
☐ Digestive problems
☐ Pain in jaw bone or joint
☐ Facial pain
☐ Head pain
☐ Are you currently in pain? — Yes ☐ No ☐
☐ Teeth do not meet properly
☐ Loss of teeth
☐ Poorly fitting dental appliance
☐ Gagging easily
☐ Pain when swallowing
☐ Other_____

☐ Do you feel your oral condition is affecting your general health in any way? _____

_____

DENTAL HISTORY

When was your last dental visit? _____

Have you ever had any complications during or after dental treatment? ☐ No ☐ Yes → Explain _____

_____

Dental Anxiety or Fear? ☐ No ☐ Yes — Level (1–10): _____

What dental treatments have you had in the past? _____

_____

Why were the treatments done? _____

_____

Have you ever had a negative experience at a dental office? _____

_____

Have you ever experienced gum issues, periodontal disease, or gum surgery? _____

_____

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Have you lost any teeth? ☐ No ☐ Yes — Which teeth: _____

_____

Have the missing teeth been replaced? If yes, how? (bridge, denture, implant, etc.) _____

_____

Have you ever been told you have bone loss or periodontal disease?☐ No ☐ Yes — When: _____

Treatment Received: _____

Do you grind or clench your teeth? ☐ No ☐ Yes — ☐ Daytime ☐ Nighttime

Do you snore, breathe through your mouth, or wake with headaches or jaw discomfort?

☐ Yes ☐ No ☐ Not Sure

Have you ever been screened for sleep apnea or airway issues? ☐ Yes ☐ No

Have you been hospitalized or had surgery? _____

Primary Care Provider:_____

Specialists You See Regularly: _____

HAVE YOU EVER HAD OR USED ANY OF THE FOLLOWING:

☐ Braces
☐ Retainers
☐ Nightguard
☐ Dentures
☐ Invisalign
☐ Wisdom teeth removed
☐ Dental implants
☐ Bone grafting
☐ Jaw surgery
☐ Periodontal (gum) treatment

MEDICAL HISTORY

- ☐ Anemia
- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ Autoimmune disorders
- ☐ Bleeding easily
- ☐ Blood pressure — High ☐ / Low ☐
- ☐ Bruising easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Bronchitis
- ☐ Chronic fatigue
- ☐ Current pregnancy
- ☐ Depression
- ☐ Diabetes — ☐ Type I ☐ Type II
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart pacemaker
- ☐ Heart valve replacement
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypoglycemia
- ☐ Immune system disorder
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Nasal stuffiness in the morning
- ☐ Osteoporosis
- ☐ Psychiatric treatment
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Stroke
- ☐ Tumors
- ☐ Tendency for frequent colds
- ☐ Tuberculosis
- ☐ Injury to: ☐ Face ☐ Neck ☐ Mouth ☐ Teeth
- ☐ Other _____
- ☐ _____
- ☐ None

LIST MEDICATIONS/SUBSTANCES YOU ARE CURRENTLY TAKING:

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Insulin
- ☐ Anticoagulants
- ☐ Muscle Relaxants
- ☐ Barbiturates
- ☐ Nerve pills
- ☐ Blood thinners
- ☐ Pain medication
- ☐ Codeine
- ☐ Sleeping pills
- ☐ Ginkgo Biloba
- ☐ Heart medication
- ☐ Medications for osteoporosis
- ☐ Bisphosphonates
- ☐ Anti-anxiety medication
- ☐ Herbal supplements
- ☐ Other _____
- ☐ _____
- ☐ _____
- ☐ None

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Latex
- ☐ Sleeping pill
- ☐ Other _____
- ☐ None

LIFESTYLE & SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Former ☐ Current — Type: _____Packs/day: _____

Alcohol Use: ☐ None ☐ Social ☐ Daily — Amount: _____

Recreational Drug Use: ☐ None ☐ Yes — Type: _____

Exercise: ☐ None ☐ Occasionally ☐ Regularly

Diet: ☐ Standard ☐ Vegetarian/Vegan ☐ Diabetic ☐ Other: _____

Pregnant/Nursing: ☐ No ☐ Yes

Height: _____ ft _____ in Weight: _____ lbs

Blood Pressure (Today): _____ / _____

YOUR GOALS & PREFERENCES

How satisfied are you with your smile today?

❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10

How motivated are you to improve it?

❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10

If you could wave a magic wand and change anything about your mouth, what would it be? _____

_____

What do you look for in a dentist and their team?_____

_____

Do you have any budget concerns or monthly payment goals? ☐ No ☐ Yes — Please describe: _____

_____

Are you open to discussing financing options or payment plans? ☐ Yes ☐ No

Is there anything that could stand in the way of you getting the care you need (financial, time, fear, etc.)?

_____

Do you have any time constraints or deadlines for treatment? ☐ No ☐ Yes — Explain:_____

_____

How do you prefer to receive appointment reminders? ☐ Call ☐ Text ☐ Email

Is there anyone else involved in decision-making for your dental care?

☐ No ☐ Yes — Name/Relationship: _____

What specific treatments or services are you curious to learn more about?

☐ Dental Implants ☐ Veneers ☐ Invisalign ☐ Whitening

☐ Full Mouth Reconstruction ☐ Botox / TMJ Therapy ☐ Sedation Dentistry