OMENE FAMILY AND COSMETIC DENTISTRY | Where great smiles begin.

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New Patient Dental Intake Form

PATIENT INFORMATION

Name:_____ Birthdate: _____

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

Home phone:_____ Cell phone:_____ Email:_____

Sex: ○ M ○ F Marital status: ○ Single ○ Married ○ Divorced ○ Separated ○ Partnership ○ Widowed

Employer or School:_____ Work Phone:_____

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

Spouse,partner or parent name:_____

Person to contact in case of an emergency:_____ Phone:_____

How did you learn about our practice or whom may we thank for referring you?_____

Who is responsible for your account and payment? (if different from previous listing):_____

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

Phone:_____ Email:_____ Birthdate:_____

DENTAL INSURANCE

Insurance Company:_____ Phone:_____

Subscriber's Social Security #:_____ Group #:_____ ID #_____

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

How much is your deductible?_____ How much have you used?_____ What is your annual maximum benefit?_____

Whose name is this insurance under?_____

Employer offering this insurance?_____ Phone:_____

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

SECONDARY DENTAL INSURANCE

Insurance Company:_____ Phone:_____

Subscriber's Social Security #:_____ Group #:_____ ID #_____

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

How much is your deductible?_____ How much have you used?_____ What is your annual maximum benefit?_____

Whose name is this insurance under?_____

Employer offering this insurance?_____ Phone:_____

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

DENTAL HISTORY

Reason for today's visit:_____

Date of last dental care visit:_____ Date of last dental x-rays:_____

Former dentist's name:_____ Phone:_____

Check if you have any problem with the following:

- ○ Bad breath
- ○ Bleeding gums
- ○ Clicking or popping jaw
- ○ Food collection between certain teeth
- ○ Grinding teeth
- ○ Loose teeth or broken fillings
- ○ Periodontal treatment
- ○ Sensitivity to any of the following: cold, hot, sweets
- ○ Sensitivity when biting
- ○ Sores or growth in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Your physician:_____ Date of last visit:_____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? ○ **YES** ○ **NO**

Have you had any serious illnesses or operations? ○ **YES** ○ **NO**

If yes, describe:_____

Have you ever had a blood transfusion? ○ **YES** ○ **NO**

If yes, give approximate dates:_____

Women: Are you pregnant? ○ **YES** ○ **NO** Are you nursing? ○ **YES** ○ **NO** Are you taking birth control? ○ **YES** ○ **NO**

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ○ Anemia
- ○ Arthritis, rheumatism
- ○ Artificial heart valves
- ○ Artificial joints, pins, etc.
- ○ Asthma
- ○ Bleeding abnormally
- ○ Blood disease
- ○ Cancer
- ○ Chemical dependency
- ○ Chemotherapy
- ○ Circulatory problems
- ○ Congenital heart lesions
- ○ Diabetes
- ○ Epilepsy
- ○ Fainting
- ○ Glaucoma
- ○ Headaches
- ○ Heart murmur
- ○ Heart problems
- ○ Hemophilia
- ○ Hepatitis
- ○ High blood pressure
- ○ HIV AIDS
- ○ Jaw pain
- ○ Kidney disease
- ○ Liver disease
- ○ Mitral valve prolapse
- ○ Pacemaker
- ○ Radiation treatment
- ○ Respiratory disease
- ○ Rheumatic fever
- ○ Scarlet fever
- ○ Sexually transmitted disease
- ○ Stroke
- ○ Swelling of feet or ankles
- ○ Thyroid problems
- ○ Tobacco use
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Ulcer

List medications you are currently taking and the correlating diagnosis:

MEDICATION	DIAGNOSIS

Please list any allergies you may have:

ALLERGY	ALLERGY

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

PATIENT OR GUARDIAN SIGNATURE **DATE**

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