

**NEW PATIENT
INTAKE FORM**
(PLEASE PRINT)



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Mequon, WI 53092
(262)242-1180
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Family and Cosmetic Dentistry
Craig L. Smith, DDS

Date _____ Cell Phone (____) _____ Home Phone (____) _____

PATIENT INFORMATION

Name _____ SSN/Chart # _____
First Name Middle Initial Last Name

Address _____ E-mail _____
 City _____ State _____ Zip _____

Sex M F Age _____ Date of Birth _____
 Married Widowed Single Minor

Employer/School _____
 Divorced Partnered for _____ years

Occupation _____ Emp/School Phone (____) _____

Referred By _____

Emergency Contact _____ Phone (____) _____

INSURANCE INFORMATION

Subscriber Name _____ SSN/Member ID _____
 Date of Birth _____ Relation to Patient _____ Group # _____
 Dental Insurance Company _____ Insurance Phone(____) _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____ SSN/Member ID _____
 Date of Birth _____ Relation to Patient _____ Group # _____
 Dental Insurance Company _____ Insurance Phone(____) _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign
Name of Insurance Company(ies)
 directly to Dr. Craig Smith all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative _____
Date

 Please print name of Patient, Parent, Guardian or Personal Representative _____
Relationship to Patient



CHIEF COMPLAINT / DENTAL HISTORY

Previous Dentist _____ Date of Last Visit _____

Check (✓) if you have had, or currently have, problems with any of the following

- | | | |
|--|--|---|
| <input type="checkbox"/> Pain when chewing | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Teeth do not meet properly |
| <input type="checkbox"/> Sensitivity to hot/cold | <input type="checkbox"/> Tingling in jawbone | <input type="checkbox"/> Numbness in lower lip or jawbone |
| <input type="checkbox"/> Jaw clicking or locking | <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Diet limited to semisolid, soft, or liquid foods |
| <input type="checkbox"/> Limited or difficult opening of mouth | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding / clenching of teeth |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Daytime <input type="checkbox"/> Nighttime <input type="checkbox"/> Both |
| <input type="checkbox"/> Mouth sores / ulcers —
<input type="checkbox"/> Upper <input type="checkbox"/> Lower | <input type="checkbox"/> Nutritional disorders | <input type="checkbox"/> Poorly fitting dental appliance |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Pain in jaw bone or joint | <input type="checkbox"/> Gagging easily |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Pain when swallowing |
| | <input type="checkbox"/> Head pain | <input type="checkbox"/> Other _____ |

Reason for Today's Visit _____

Do you have any concerns? Yes No

If **YES**, please explain _____

Are you currently in pain? Yes No

If **YES**, please explain _____

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 you feel your oral condition is affecting your general health in any way? Yes No

If **YES**, please explain _____

Have you ever had any complications during or after dental treatment? Yes No

If **YES**, please explain _____

Dental Anxiety or Fear? Yes No

Severity (1-10): _____

What dental treatments have you had in the past?

- | | | | |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> Braces | <input type="checkbox"/> Tooth Extractions | <input type="checkbox"/> Nightguard | <input type="checkbox"/> Jaw surgery |
| <input type="checkbox"/> Invisalign | <input type="checkbox"/> Bone grafting | <input type="checkbox"/> Dental implants | <input type="checkbox"/> Periodontal (gum) treatment |
| <input type="checkbox"/> Retainers | <input type="checkbox"/> Dentures | <input type="checkbox"/> Other | |

Why were the treatments done? _____

Have you ever had a negative experience at a dental office? Yes No

If **YES**, please explain _____

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



MEDICAL HISTORY

Primary Care Provider _____ Date of Last Visit _____

Have you been hospitalized or had surgery? Yes No

If **YES**, please explain: _____

Do you take, or have you taken, Fen-Phen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

If **YES**, please explain: _____

Do you use controlled substances? Yes No

Women, are you pregnant? Yes No Nursing? Yes No Taking birth control? Yes No

Check (✓) if you have had, or currently have, problems with any of the following

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Injury to: |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Mouth/Teeth |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemophilia | | _____ |

MEDICATIONS

Check (✓) if you are currently taking any of the following, and list the prescription name on line provided

- Anti-anxiety medication _____
- Antibiotic(s) _____
- Antihistamines _____
- Aspirin _____
- Blood thinners — Anticoagulants Antiplatelets _____
- Blood Pressure Medication _____
- Heart medication _____
- Insulin _____
- Muscle Relaxants _____
- Nerve Pain Medication _____
- Osteoporosis Medication _____
- Pain Medication _____
- Sleeping Medication _____
- Supplements _____
- Other _____

Preferred Pharmacy: _____ Phone (____) _____



ALLERGIES

- Aspirin Codeine Penicillin Antibiotics _____
 Latex Local Anesthetic Sulfa Other _____

LIFESTYLE AND SOCIAL HISTORY

Tobacco Use: Never Former Current — Type _____ Amount _____
Alcohol Use: Never Social Daily — Amount _____
Recreational Drug Use: None Yes — Type _____
Exercise: None Occasionally Regularly
Diet: Standard Vegetarian/Vegan Diabetic Other: _____
Height: _____ ft _____ in Weight: _____ lbs

GOALS AND 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?
 Yes No — Explain: _____
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.)?
 Yes No — Explain: _____
Do you have any time constraints or deadlines for treatment?
 Yes No — Explain: _____
How do you prefer to receive appointment reminders? Call Text Email
Is there anyone else involved in decision-making for your dental care?
 Yes No — Name/Relationship: _____
What specific treatments or services are you curious to learn more about?
 Dental Implants Whitening Invisalign Botox / TMJ Therapy
 Sedation Dentistry Veneers Full Mouth Reconstruction

ASSIGNMENT AND RELEASE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature _____ Date _____