Trophy Smiles of Durham

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.

PATIENT INFORMATION

Patient's Name: ☐ Male ☐ Female

Address: City: State: Zip:

Home Phone: Work Phone: Email:

Preferred Name: Date of Birth (mm/dd/yyyy):

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 Name of Orthodontist:
When:

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 describes:

FEMALE ONLY

Is patient on any type of prescribed birth control? ☐YES ☐NO If YES, please specify: Age of first menses:

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

By signing below, I certify that the information provided above is accurate and true to the best of my knowledge.

Signature: Date:

Print Name: Relationship to patient:

Patient's Name: Birth Date:

Reason for today's visit: □Routine Check-up □ Evaluation of specific concern:

REFERRAL SOURCE

How did you hear about our practice? □ Internet, website:

□ Doctor name: □ Patient Name:

□ Insurance Company: □ Other:

RESPONSIBLE PARTIES

Patient lives with: □ Father □ Mother □ Legal Guardian For Legal Guardians, can you provide legal documentation? □ Yes □ No

Father:

Address:

City, State, Zip:

Home phone #: ( )

Work phone #: ( )

Email:

Mother:

Address:

City, State, Zip:

Home phone #: ( )

Work phone #: ( )

Email:

Other than the persons named above, are there other individuals authorized to make treatment/financial decisions for this patient? □ Yes □No

Name: Relationship to patient:

Name: Relationship to patient:

INSURANCE INFORMATION

Insurance Company: Insurance phone #: ( )

Insurance Address:

Policy Holder: Relationship to Patient:

Policy #: Social Security #: Birth Date:

Employer/Group Name: Group #:

EMERGENCY CONTACTS

Name: Phone #: ( ) Relationship to Patient:

Name: Phone #: ( ) Relationship to Patient:

PATIENT PHOTO DISPLAYING CONSENT

We display his/her photo on our website and other 0
No Cavity Club board? □Yes □No

ACKNOWLEDGEMENT

By signing below, I certify that the information provided above is accurate and to the best of my knowledge. In the event that there is any issue regarding custody of a minor patient, I understand that Arthur Reynolds Jr. & Associates must be provided with court-sanctioned custody papers that clearly describe custody arrangements and designates one individual who is authorized to consent treatment and who is financially responsible for incurred charges. Arthur Reynolds Jr. & Associates reserves the right to defer or refuse treatment. I also acknowledge that I have received, read and understood the practice's Office Policies and Financial Policies.

Signature: **Date:**

Print Name: **Relationship to Patient:**