Patient Intake Form

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All Answers are confidential.

PATIENT INFORMATION

Todays Date:_____

First Name _____ Last Name _____ Date of Birth _____

Sex ____ SS#:_____ Email Address _____

Address _____ City _____ State _____ Zip Code _____

Home Phone ( )_____ Cell Phone ( )_____ FAX #:_____

Name of facility/group home:_____ Contact name/number:_____

LEGAL GUARDIAN/POWER OF ATTORNEY **(PROVIDE GUARDIANSHIP PAPERS)

Name _____ Relationship _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Name _____ Relationship _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

INSURANCE INFORMATION **(PROVIDE COPYS OF ALL INSURANCE CARDS FRONT & BACK)

PRIMARY

Insurance Carrier _____ Insurance Plan _____

Contact Number _____ Policy Number _____

Group Number _____ Social Security Number _____

MEDICARE #:_____ MEDICAID #:_____

ADDITIONAL INSURANCE **(PROVIDE COPYS OF ALL INSURANCE CARDS FRONT & BACK)

SECONDARY

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDAY OF INSURED:_____ SOCIAL SECURITY # OF INSURED:_____

INSURANCE CARRIER:_____POLICY NUMBER: _____

INSURED ADDRESS:_____

EMPLOYER:_____

ADDITIONAL INSURANCE **(PROVIDE COPYS OF ALL INSURANCE CARDS FRONT & BACK)

NAME OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDAY OF INSURED:_____ SOCIAL SECURITY # OF INSURED:_____

INSURANCE CARRIER:_____POLICY NUMBER: _____

INSURED ADDRESS:_____

EMPLOYER:_____

PLEASE NOTE IF INSURANCE PROVIDED IS INACCURATE OR INACTIVE YOU WILL BE RESPONSIBLE FOR PAYMENT

Patient Intake Form

DENTAL HISTORY

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All Answers are confidential.

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

PATIENT'S DENTAL HISTORY

REASON FOR THIS VISIT:_____
_____

LAST DENTAL VISIT: _____

WHAT WAS DONE?_____

NAME OF PREVIOUS DENTIST:_____

IS PATIENT COOPERATIVE? EXPLAIN_____
_____

HAVE YOU HAD X-RAYS TAKEN WHEN/ WHERE?
_____
****SUPPLY A COPY****

ANY DIFFICULT EXTRACTIONS IN THE PAST?
_____

HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?_____
_____

IS THE PATIENT EDENTULOUS (WITHOUT TEETH) ?_____

DO YOU WEAR DENTURES OR PARTIALS, IF YES, DATE OF PLACEMENT?_____
_____

HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?_____

HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE?_____

HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?_____
_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

___BAD BREATH

___BLEEDING GUMS

___BLISTERS ON LIPS OR MOUTH

___SORES/LUMPS AROUND MOUTH

___CHEW ONE SIDE OF MOUTH

___CIGARETTE/CIGAR SMOKING

___TOBACCO CHEWING

___GRINDING TEETH

___SWELLING OF GUMS

___DRY MOUTH

___TUBE FED

___MOUTH PAIN

___SENSITIVITY TO HOT

___SENSITIVITY TO COLD

___SENSITIVITY TO SWEETS

___IF SO WHERE...
_____

___JAW INJURIES EXPLAIN..._____
_____

___TEETH PAIN EXPLAIN..._____
_____

Patient Intake Form

Medical Part 1

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All Answers are confidential.

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Put a check next to all that apply

___ **Abnormal Bleeding after extractions, Surgery, or trauma**
___ **explain:**_____
___ **ADD**
___ **ADHD**
___ **AIDS or HIV positive**
___ **Alcoholism**
___ **Alzheimers, dementia**
___ **Anemia or Hemophilia**
___ **Angina**
___ **Anxiety or depression**
___ **Arthritis, Rheumatism**
___ **Artificial joint...explain:**_____
_____
___ **Artificial heart valve....explain:**_____
_____
___ **Asthma or Emphysema**
___ **Autism**
___ **Aspergers**
___ **Back problems**
___ **Bi-polar**
___ **Blind**
___ **Blood disease...explain** _____
_____
___ **Bleeding disorder...explain** _____
_____
___ **Taking blood thinners**
___ **Plavix**
___ **Eliquis**
___ **Coumadin**
___ **Lovenox**
___ **Cancer...explain**_____
_____
___ **Can swallow pills?**
___ **Cerebral Palsy**
___ **Cervical Spine fusion**
___ **Chemical Dependency....explain**_____
_____
___ **Chemotherapy**
___ **Chest pain**
___ **Circulatory problems**
___ **Congenital Heart Defect...explain**_____
_____
___ **Cortisone treatment**
___ **Cough, persistent or bloody....explain**_____
_____
___ **Cystic fibrosis**
___ **Deaf**

___ **Depression...explain**_____
_____
___ **Diabetes**
___ **Down Syndrome**
___ **Eating disorder**
___ **Epilepsy.....date of last seizure and frequency**_____
_____
___ **Fainting or dizzy spells explain**_____
_____
___ **Feeding tube**
___ **Fetal Alcohol Syndrome**
___ **Fragile X**
___ **Genetic syndrome**
___ **Glaucoma**
___ **Hay fever or sinus trouble**
___ **Hearing impaired**
___ **Heart Attack**
___ **Heart condition.....explain**_____
_____
___ **Heart murmur**
___ **Heart Surgery...explain**_____
_____
___ **Headaches**
___ **Hepatitis (A,B,C, or carrier)....explain**_____
___ **Hemophilia**
___ **Herpes or cold sores.**
___ **High blood pressure**
___ **Hives**
___ **Huntingtons disease**
___ **Hypoglycemia**
___ **Intellectual disability...explain and indicate mild, moderate, or advanced)**_____
_____
___ **Intermittent Explosive Disorder**
___ **Jaundice**
___ **Jaw pain**
___ **Kidney disease**
___ **Leukemia**
___ **Liver Disease**
___ **Low blood pressure**
___ **Lung or breathing problems**
___ **Malignant hyperthermia**
___ **Migraines**
___ **Mitral valve prolapse**
___ **Mental Retardation**
___ **MS**
___ **Muscular Dystrophy**
___ **Nervous problems**

_____

Patient Intake Form

Medical Part 2

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All Answers are confidential.

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Put a check next to all that apply

___ Neurologic condition
___ Non-Verbal
___ Obsessive-compulsive disorder
___ Organ Transplant...explain_____
_____
___ Oxygen use or use of C-PAP machine....explain_____
_____
___ Pacemaker
___ Phobic
___ PICA
___ Post-traumatic stress disorder
___ Radiation treatment
___ Rett's Syndrome Tourettes
___ Respiratory disease...explain_____
___ Rheumatic fever or heart disease...explain_____
___ Scarlet fever
___ Schizophrenia
___ Seizures...explain date of last and frequency_____
_____
___ Shortness of breath
___ Sickle Cell Disease or trait...explain_____
_____
___ Sinus problems
___ Skin rash
___ Sleep apnea specify treated or untreated _____
_____
___ Special Diet....explain_____
_____
___ Spina bifita
___ Spinal cord disease...explain_____
___ Spinal Fusion...where_____
___ Stoke....explain_____
_____
___ Swollen feet, ankles or hands...explain _____
_____
___ Swollen neck or glands
___ Stomach ulcers
___ Thyroid Disease
___ Thrombocytopenia
___ Tracheostomy
___ Traumatic Brain injury
___ Tonsilitis
___ Tuberculosis
___ Tumors...explain _____
___ Ulcer
___ Venereal disease
___ Wheel chair bound, use of cane ,walker or Stretcher...
explain_____

Please list any condition or illness patient may have that has not been mentioned:____

_____

_____

Have you ever been hospitalized for any illness or operation? explain:_____

_____

Allergies:_____

_____

_____

Height:___Weight: _____ Sex:____Age:___

Medications: _____*Attach a list***_____**

Do you require pre-medication (antibiotic) before dental work?_____

Have you ever taken Fosamax, Boniva, Actonel, Didronel, Reclast or any medication containing bisphosphonates? Explain_____

_____

Any contradictions to general anesthesia?

_____

Is sedation needed?_____

Primary Care Doctor:_____

Phone number:_____

Fax:_____

Address:_____

_____

Date of last Physical exam:_____

Pharmacy:_____

Phone number:_____

Address:_____

_____

SPECIAL NEEDS PATIENT INFORMATION

S/N PATIENT NAME_____ DOB_____

S/N PATIENTS ADDRESS_____

_____

S/N PATIENTS MEDICAL CONDITION _____

FACILITY NAME_____ SUPERVISOR NAME_____

FACILITY PHONE#_____ SUPERVISOR CELL#_____

FACILITY FAX# _____

SUPERVISOR E-MAIL _____

DENTAL INSURANCE_____MEMBER ID#_____

**IF MULTIPLE INSURANCES/WHOSE INSURANCE/RELATIONSHIP/AND THEIR DOB

_____

DO THEY NEED SEDATION? YES or NO

MOTHERS NAME_____ FATHERS NAME_____

WHO IS LEGAL GUARDIAN? _____ PHONE#_____

LAST DENTL VISIT_____ ANY X-RAYS? YES or NO

REFERRED BY_____

APPOINTMENT SCHEDULED FOR_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

SIMPLY SPECIAL DENTAL OF VOORHEES
RICHARD ROSENTHAL, DMD, JD
1000 WHITE HORSE ROAD
SUITE 916
VOORHESS TOWNSHIP, NJ 08043
(856)-772-0007
(856)-545-3295(FAX)
SIMPLYSPECIALDENTAL@YAHOO.COM
SIMPLYSPECIALDENTALVOORHEES@GMAIL.COM

Patient Information Update

******Please provide updated medication list, insurance cards, guardianship papers******

Today's Date _____

Patients Name _____ DOB _____

Address _____

_____

Facility Name _____

Facility Phone # _____ Facility Fax # _____

Primary Aid Name _____ Phone# _____

email _____

Supervisor Name _____ Phone# _____

email _____

****

Today's Weight _____ Today's Height _____ BMI _____

List health changes in past year _____

_____

Primary Care Physician Name _____

Primary Care Physicians Address _____

Primary Care Physicians Phone # _____ fax# _____

****

Mothers Name _____

Fathers Name _____

Legal Guardian Name _____ Relationship _____

Legal Guardian Phone # _____

****

Dental Insurance _____

Member ID # _____

Carriers Name _____

Carriers DOB _____ Carriers Relationship to Patient _____

Carriers address _____

Additional Insurance _____

Member ID # _____

Carriers Name _____

Carriers DOB _____ Carriers Relationship to Patient _____

Carriers address _____