Habijanac Perio

**NEW PATIENT INTAKE FORM**

NAME: _____ DATE OF BIRTH (MM/DD/YYYY): _____
ADDRESS: _____ CITY: _____
POSTAL CODE: _____
PHONE: _____ PHONE (OTHER): _____
EMAIL: _____
EMERGENCY CONTACT: _____ EMERGENCY PHONE: _____

**PRIMARY INSURANCE INFORMATION:**
NAME OF INSURANCE COMPANY: _____ NAME OF POLICY HOLDER: _____
POLICY HOLDER D.O.B.: _____ RELATION TO PT: _____
POLICY/CONTRACT #: _____ CERTIFICATE/ID #: _____

**SECONDARY INSURANCE INFORMATION:**
NAME OF INSURANCE COMPANY: _____ NAME OF POLICY HOLDER: _____
POLICY HOLDER D.O.B.: _____ RELATION TO PT: _____
POLICY/CONTRACT #: _____ CERTIFICATE/ID #: _____

PRIMARY PHYSICIAN: _____ CONTACT #: _____
OTHER MEDICAL SPECIALISTS: _____ CONTACT #: _____
REFERRING DENTIST: _____ GENERAL DENTIST: _____

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**DENTAL AND MEDICAL INFORMATION**
REASON FOR REFERRAL/CHIEF DENTAL COMPLAINT: _____
_____

HOW OFTEN ARE YOU SEEN FOR IN-OFFICE DENTAL HYGIENE VISITS? _____
PREVIOUS/CURRENT DENTAL TREATMENT:

- **ORTHODONTIC THERAPY** Y N
- **ORTHOGNATHIC/JAW SURGERY** Y N
- **ENDODONTIC THERAPY (ROOT CANAL)** Y N
- **TOOTH EXTRACTIONS** Y N
- **FILLINGS** Y N
- **CROWNS/BRIDGES** Y N
- **DENTAL IMPLANTS** Y N
- **OTHER** _____

HAVE YOU PREVIOUSLY BEEN UNDER THE CARE OF A PERIODONTIST? Y N

**MEDICATIONS AND DOSAGE:** (Please include prescription, over the counter, supplements)

_____

_____

**ALLERGIES:** (Please list all allergies and intolerances, mild and severe)

_____

_____

**HAVE YOU HAD ANY REACTIONS TO:**

DENTAL ANESTHETICS Y N DK ANTIBIOTICS Y N DK

**LIFESTYLE HABITS:**

SMOKING/VAPING Y N HOW OFTEN PER DAY? _____

ALCOHOL Y N HOW OFTEN PER DAY? _____

OTHER SUBSTANCES Y N _____

**CURRENT MEDICAL CONDITIONS AND DIAGNOSES:** _____

_____

PLEASE CIRCLE YES(Y), NO (N) OR DON'T KNOW (DK) FOR THE FOLLOWING:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **HEART CONDITION** | Y | N | DK | **RHEUMATIC FEVER** | Y | N | DK |
| **HEART MURMUR** | Y | N | DK | **HEART ATTACK** | Y | N | DK |
| **HEART SURGERY** | Y | N | DK | **CONGESTIVE HEART DISEASE** | Y | N | DK |
| **STROKE** | Y | N | DK | **HIGH BLOOD PRESSURE** | Y | N | DK |
| **ASTHMA OR COPD** | Y | N | DK | **BENIGN TUMOUR** | Y | N | DK |
| **CANCER** | Y | N | DK | **TYPE OF CANCER** _____ | | | |
| **CANCER TREATMENT**: | SURGERY | | RADIATION | CHEMOTHERAPY | IV BISPHOSPHONATES | | |
| **DIABETES** | Y | N | DK | **KIDNEY PROBLEMS** | Y | N | DK |
| **SEIZURE DISORDER** | Y | N | DK | **BLEEDING DISORDER** | Y | N | DK |
| **LIVER DISEASE** | Y | N | DK | **HEPATITIS** | Y | N | DK |
| **HIV/AIDS** | Y | N | DK | **THYROID DISORDER** | Y | N | DK |
| **ARTHRITIS** | Y | N | DK | **SINUSITIS** | Y | N | DK |
| **OSTEOPOROSIS** | Y | N | DK | **AUTOIMMUNE CONDITIONS** | Y | N | DK |
| **GENETIC DISORDERS** | Y | N | DK | **MENTAL HEALTH DISORDER** | Y | N | DK |
| **PROSTHETIC OR ARTIFICAL JOINT/IN-DWELLING MEDICAL DEVICES (KNEE/HIP)** | | | | | Y | N | DK |

**OTHER** _____

**MEN: PROSTATE DISORDER** Y N MEDICATIONS TAKEN _____

**WOMEN:**

ARE YOU CURRENTLY

PREGNANT? Y N DK EXPECTED DUE DATE: _____

BREASTFEEDING? Y N

REACHED MENOPAUSE Y N

DO YOU TAKE ORAL CONTRACEPTIVES OR HORMONES? Y N

**SIGNATURE: _____ DATE FORM COMPLETED: _____**