SALMON CREEK
COMPLETE
DENTISTRY

Patient Intake Form

Email Address:	Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Information

First Name:	Last Name:	Middle Initial:

Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact:

- ☐ Phone
- ☐ Text
- ☐ Email

Mailing Address:	City:	State:	ZIP:

Date of Birth:	Sex:

Occupation:	Emergency Contact:

How did you hear about us? Who referred you here?

If you are completing this form for another person, what is your relationship to that person?

Your Name:	Relationship:

Home Phone:	Cell Phone:

Dental Information

Are your teeth sensitive to cold, hot, sweets or pressure?
- ☐ Yes
- ☐ No

Does food or floss catch between your teeth?
- ☐ Yes
- ☐ No

Is your mouth dry?
- ☐ Yes
- ☐ No

Have you had any periodontal (gum) treatments?
- ☐ Yes
- ☐ No

Have you ever had orthodontic (braces/clear aligner) treatment?
- ☐ Yes
- ☐ No

Have you ever had any problems associated with previous dental treatment?
- ☐ Yes
- ☐ No

Have you ever been told you stopped breathing at night or snored?
- ☐ Yes
- ☐ No

Are you currently experiencing dental pain or discomfort?
- ☐ Yes
- ☐ No

Do you have earaches, neck pains, or migraines?
- ☐ Yes
- ☐ No

Do you have any clicking, popping, or discomfort in the jaw?
- ☐ Yes
- ☐ No

Do you clench, brux, or grind your teeth?
- ☐ Yes
- ☐ No

Do you have sores or ulcers in your mouth?
- ☐ Yes
- ☐ No

Do you wear dentures or partials?
- ☐ Yes
- ☐ No

Do you participate in active recreational activities?
- ☐ Yes
- ☐ No

Have you ever had a serious injury to your head or mouth?
- ☐ Yes
- ☐ No

Are you happy with the appearance of your teeth and smile?
- ☐ Yes
- ☐ No

If not, why? ______________________

Chief Dental Complaint?

Date of your last dental exam	What was done at that time?

Date of last dental x-rays	Reason for visit?

Medical Information

Are you currently under the care of a physician?

- ☐ Yes
- ☐ No

Physician Name:	Phone Number:

Address/City/State/Zip:

Are you in good health?

- ☐ Yes
- ☐ No

Has There been a change in your general health within the past year?

- ☐ Yes
- ☐ No

If "Yes" what condition is being treated?

Date of last physical exam?

Do you have a history of chemical dependency?

- ☐ Yes
- ☐ No

Are you in recovery?

- ☐ Yes
- ☐ No
- ☐ N/A

If "Yes", how long have you been in recovery?

Have you had a serious illness or been hospitalized in the past 5 years?

- ☐ Yes
- ☐ No

If "Yes" what was the illness or problem?

Do you take any blood thinners?

- ☐ Yes
- ☐ No

Do you take aspirin on a regular basis?

- ☐ Yes
- ☐ No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risdronate (Actonel) for osteoporosis or Paget's disease?

- ☐ Yes
- ☐ No

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

- ☐ Yes
- ☐ No

If "Yes" please list all medications, including vitamins, natural or herbal preparations and/or diet supplements

Do you use controlled substances (drugs)?
- ☐ Yes
- ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)?
- ☐ Yes
- ☐ No

If so, how interested are you in stopping?
- ☐ Very
- ☐ Somewhat
- ☐ Not Interested

Do you drink alcohol?
- ☐ Yes
- ☐ No

If “Yes”, how much alcohol did you drink in the last 24 hours?

WOMEN ONLY are you:

Pregnant?
- ☐ Yes
- ☐ No

Number of weeks

Taking birth control or hormonal replacements?
- ☐ Yes
- ☐ No

Nursing?
- ☐ Yes
- ☐ No

Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement?
- ☐ Yes
- ☐ No

If yes, date:

If yes, have you had any complications?

ALLERGIES Please mark “Yes” if you are allergic to (or have had a reaction to the following:

Local anesthetics
- ☐ Yes
- ☐ No

Aspirin (NSAIDs)
- ☐ Yes
- ☐ No

Penicillin or other antibiotics
- ☐ Yes
- ☐ No

Barbiturates, sedatives, or sleeping pills
- ☐ Yes
- ☐ No

Sulfa Drugs
- ☐ Yes
- ☐ No

Codeine or other narcotics
- ☐ Yes
- ☐ No

Metals
- ☐ Yes
- ☐ No

Latex (rubber)
- ☐ Yes
- ☐ No

Iodine
- ☐ Yes
- ☐ No

Hay fever/seasonal
- ☐ Yes
- ☐ No

Animals
- ☐ Yes
- ☐ No

Food/Other
- ☐ Yes
- ☐ No

Specify:

Please circle if you have (or have had) any of the following diseases or problems.

Heart murmur	Blood transfusion	Diabetes type I or type II	Mental health disorders
Mitral valve prolapse	Hemophilia	Eating disorder	Recurrent infection
Artificial heart valves	AIDSor HIV infection	Malnutrition	Kidney problems
Rheumatic fever	Arthritis	Gastrointestinal disease	Night sweats
Cardiovascular disease	Autoimmune disease	GE Reflux/persistent heartburn	Osteoporosis
Angina Arteriosclerosis	Rheumatoid arthritis	Ulcers	Persistent swollen glands in neck
Congestive heart failure	Systemic Lupus erythematosus	Thyroid problems	Severe headaches/migraines
Coronary artery disease	Asthma	Stroke	Severe/rapid weight loss
Damaged heart valves	Bronchitis	Glaucoma	STDs/STIs
Heart attack	Emphysema	Hepatitis, jaundice, or liver disease	Excessive urination
Low blood pressure	Sinus Trouble	Epilepsy	ADD
High blood pressure	Tuberculosis	Fainting spells or seizures	ADHD
Congenital heart defects	Cancer/Chemotherapy/ Radiation treatment	Neurological disorders	Sensory processing disorder
Pacemaker	Chest pain upon exertion	Gag Reflex sensitivity	Oral sensory sensitivity
Rheumatic heart disease	Chronic pain	Sleep disorder	
Abnormal bleeding Anemia			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

- ☐ Yes
- ☐ No

Do you have any disease, condition, or problem not listed above that you think we should know about?

- ☐ Yes
- ☐ No

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Phone

Pharmacy Address

SIGNATURE

Note: *Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment*

- ☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold me doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
- ☐ I have read and understand the circumstances under which a patient may be dismissed, including but not limited to:
    - Failure to keep scheduled appointments or failure to cancel/reschedule one day (twenty-four hours) prior to the appointment. Two office visit no-shows or one missed treatment appointment can result in dismissal.
    - Failure to comply with instructions provided by the providers and/or their team.
    - Deterioration of the patient and provider relationship
    - Being disrespectful or impolite to the provider or team.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian	Date: