Patient Intake Form: Pacific One Dental

Are you a New Patient or Returning Patient? (Required) *

- ◯ New Patient
- ◯ Returning Patient
- ◯ Existing Patient

Section 1: Patient Information

In an effort to serve you better, we ask that you complete the following. We will be glad to assist you.
Please Print Clearly.

Patient Information

A Parent or Guardian will be responsible for decisions on my treatment:

- ◯ Yes
- ◯ No

Section 2: Financial Information

Legal First Name *

Legal First Name

Legal Last Name *

Legal Last Name

Preferred Name

Enter your Preferred Name

Gender Identity

- [ ] Male
- [ ] Female
- [ ] Non-binary
- [ ] Self-identify

Self-Identity:

Pronouns

- [ ] he/him
- [ ] she/her
- [ ] they/them
- [ ] other

Other:

Home Tel *

Phone

Cell:

Email *

Email

Address *

Search address

Street Address

Address

City

City

Province

Province

Country

Country

Postal Code

Postal Code

Date of birth

MM-DD-YYYY

Emergency Contact Name *

Emergency Contact Phone *

Family Doctor Name *

Family Doctor Phone *

How did you hear about us? (Required) *

Referred By (If you are referred by another patient or office, please indicate) *

Section 2: Financial Information

Responsible for financial matters

- ◯ Self
- ◯ Spouse
- ◯ Parent/Guardian
- ◯ Other

Other:

Primary Insurance:

Primary Insurance

Enter your text

Employer/Policy Holder

Enter your text

Policy #

Enter your text

Certificate #

Enter your text

Max Coverage

Enter your text

% Coverage – Basic

Enter your text

% Coverage – Maj. Restorative

Enter your text

% Coverage – Ortho

Enter your text

Secondary Insurance:

Secondary Insurance

Enter your text

Employer/Policy Holder

Enter your text

Policy #

Enter your text

Certificate #

Enter your text

Max Coverage

Enter your text

% Coverage – Basic

Enter your text

% Coverage – Maj. Restorative

Enter your text

% Coverage – Ortho

Enter your text

Section 3: Dental History

Main Concern (Required) *

Emergency, Examination, Other (please explain shortly)

Visit frequency

- ◯ 3–6 months
- ◯ Annually
- ◯ Other

When was your last dental visit?

Enter your text

When was your Last X-ray?

Enter your text

How often do you brush per day?

Enter your text

How often do you floss per day?

Enter your text

How often do you use anti-bacterial rinse?

Enter your text

Teeth sensitive to

- ☐ Cold
- ☐ Heat
- ☐ Sweets
- ☐ Other

Other:

Enter your text

Gums bleed when

- [ ] Brushing
- [ ] Flossing
- [ ] Never
- [ ] Other

Other:

Enter your text

Jaws crack/pop/grate, when you open widely?

- ( ) Yes
- ( ) No

Grind or clench teeth, regularly?

- ( ) Yes
- ( ) No

Previous dental treatment problems (Please specify)

Enter your text

Prior dental work

- [ ] Bridgework
- [ ] Crowns/Caps
- [ ] Full/Partial Dentures
- [ ] Orthodontic
- [ ] Periodontal (Gum Surgery)
- [ ] Root Canal

Section 4: Medical History

PHN #

Enter your text

Currently under physician care for any medical condition?

- ◯ Yes
- ◯ No

If yes, explain please

Enter your text

Hospitalized/major surgery?

- ◯ Yes
- ◯ No

If yes, explain please

Enter your text

Taking drugs/medications? (Includes Cannabis)

- ◯ Yes
- ◯ No

Medications

Drug name + Reason

Adverse reaction to

- ☐ Penicillin
- ☐ Sulfonamide
- ☐ Aspirin
- ☐ Codeine
- ☐ Local Anaesthetic
- ☐ NONE
- ☐ Other

Other:

Enter your text

Allergies (hay fever, latex, etc.)?

- ◯ Yes
- ◯ No

Please specify

Enter your text

Section 5: Health & Physiological Information

Bruise easily / prolonged bleeding?

- ◯ Yes
- ◯ No

Smoke or vape? How much/day?

Enter your text

Fainted, shortness of breath, chest pains?

- ◯ Yes
- ◯ No

Possibility of pregnancy?

- ◯ Yes
- ◯ No

Currently nursing?

- ◯ Yes
- ◯ No

Reached menopause?

- ◯ Yes
- ◯ No

Section 6: Medical Conditions

Do you have or have you ever had any of the following? Please check [X] appropriate boxes.

- [ ] A.I.D.S / H.I.V. Positive
- [ ] Anemia / Blood disorders
- [ ] Asthma / Bronchitis / Emphysema
- [ ] Cancer / Radiation / Chemotherapy
- [ ] Diabetes / Hypoglycemia
- [ ] Epilepsy / Seizures
- [ ] Heart Disease / Attack / Murmur
- [ ] High or Low Blood Pressure
- [ ] Hepatitis A/B/C / Liver Disease
- [ ] Kidney Disease
- [ ] Mental / Nervous / Psychiatric Disorder
- [ ] Thyroid Disease
- [ ] Ulcers / Stomach Problems
- [ ] Other

If other, please specify

Enter your text

Section 7: General Release / Signature

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other healthcare provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signing as: *

- [ ] Patient
- [ ] Parent/ Guardian

Full Name of Signee

Printed First and Last Name

Signature *

Sign here

Clear

Signature is required

Submit/ Signed Date

MM-DD-YYYY

Bot Protection

Success!

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- [ ] By checking this box, I consent to receive non-marketing text messages from **[BUSINESS NAME]** about **[USE_CASE_FROM_CAMPAIGN_DESCRIPTION]**. Message frequency varies, message & data rates may apply. Text HELP for assistance, reply STOP to opt out.

- [ ] By checking this box, I consent to receive marketing and promotional messages including special offers, discounts, new product updates among others.from **[BUSINESS NAME]** at the phone number provided. Frequency may vary. Message & data rates may apply. Text HELP for assistance, reply STOP to opt out.

Submit

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