CLIENT INTAKE FORM

Name _____ DOB _____ Age _____

Address _____

City State Zip

SSN _____ Phone _____

Email _____

Emergency Contact _____ Emergency Contact Phone _____

Insurance Carrier _____ Policy # _____ Group # _____

Subscriber's Name _____ Subscriber's DOB _____ SSN _____

How did you learn about us? (Please be specific) _____

_____

Employer/Occupation _____ Phone Number _____

Are you a college student? ☐ Yes ☐ No If yes, where? _____

Name of your medical doctor _____ Date of last visit to your medical doctor _____

Name of your previous dentist _____ Date of last visit to your previous dentist _____

May we text you? ☐ Yes ☐ No

May we email you? ☐ Yes ☐ No

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*I acknowledge that the information I provide in this paperwork is accurate and complete to the best of my knowledge. I understand that this information is necessary for my dental care and treatment and will be kept confidential in accordance with applicable laws and regulations. I consent to the use of my personal health information by the dental practice for the purposes of diagnosis, treatment, and payment, as well as for any other healthcare operations. I also understand that I have the right to request access to and correction of my personal health information.

Signature _____ Date _____

HEALTH HISTORY FORM

Do you have, or have you had any of the following?

	YES	NO
Abnormal bleeding		
Acetaminophen, ibuprofen, aspirin use		
Alcohol or drug abuse		
Anesthetic		
Artificial heart valve		
Arthritis		
Asthma		
Back or neck pain		
Blood disease (anemia)		
Blood pressure problems		
Sinus problems		
Skin rashes		
Special diet		
Stroke		
Taking allergy medication		
Taking heart medication		
Thyroid problems		
Tuberculosis		
Ulcers		
Weight gain or loss		

	YES	NO
Blood transfusion history		
Cancer/tumor		
Chest pain		
Contact lenses		
Constipation/diarrhea		
Cortisone (steroids)		
Diabetes		
Easy bruising		
Epilepsy		
Fainting spells		
Frequent nosebleeds		
Glaucoma		
Hay fever		
Head injury		
Heart murmur		
Heart valve problem		
Hepatitis		
Herpes or other STI		
HIV positive/AIDS		
Joint replacement		

	YES	NO
Jaundice		
Liver trouble		
Neurological disease		
Pacemaker		
Pre medications required by doctor		
Respiratory disease		
Rheumatic fever		
Seizure		
Severe headaches		
Shortness of breath		

In the last 12 months, have you taken any of the following?

	YES	NO
Antibiotics or sulfa drugs		
Anticoagulants		
High Blood Pressure Medication		
Tranquilizers		
Insulin, orinase, or similar drugs		
Asprin		
Digitalis or drugs for heart trouble		
Nitrogycerin		
Intravenous drugs		

Do you use tabacco?

	YES	NO
Cigarettes		
Vaping		
Nicotine Pouches		

If so, how much? _____

Do you drink alcohol?

	YES	NO

If so, how much? _____

If you marked YES to DIABETES

	YES	NO
Urinate more than 6x a day		
Constantly thirsty or dry mouth		
Family history of diabetes		

HEALTH HISTORY FORM CONTINUED

Are you allergic, or have reacted adversely to any of the following?

	YES	NO
Local anesthetic (Novocain)	☐	☐
Sulfa drugs, barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other nercotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber	☐	☐
Penicillin or other antibiotics	☐	☐

(If yes, please list): _____

Women

	YES	NO
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant	☐	☐
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐

If yes, expected delivery date? _____

Please list any other mediation or condition not listed:

_____

_____

_____

I certify that the medical history information I have provided is accurate and complete to the best of my knowledge. I understand that this information is essential for the dental practice to provide safe and appropriate care. I agree to inform the dental practice of any changes in my health status. I consent to the use of my medical history information by the dental practice for diagnosis, treatment planning, and the coordination of care. I acknowledge that my medical history will be kept confidential in compliance with all applicable laws and regulations.

Printed Name _____ **Date** _____

Signature _____ **Date** _____

FINANCIAL AGREEMENT FORM

- For my convenience, Suite Dental may release my information to my insurance company, and receive payment directly from them.

- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

- If sent to collections, I agree to pay all related fees and court costs.

- I understand that Dr. Spencer and Suite Dental are not in network with my insurance plan, and will be utilizing my out of network benefits (if any). Every effort will be made to help me with my insurance, but if my insurance does not pay as expected, I will be responsible.

- I agree to pay finance charges of 1.5% per month (18% APR) on any balance that is 90 days past due.

- I will pay $100 fee for an appointment broken without 48 business hour notice.

- Treatment plans may change, and I will be financially responsible for all work actually completed.

I acknowledge full responsibility for all charges related to my dental treatment. Payment is due at the time of service unless otherwise arranged. I authorize the dental practice to submit claims to my insurance provider on my behalf and understand that I am responsible for any remaining balance not covered by insurance. I agree to pay any outstanding balances promptly and understand that unpaid accounts may incur additional fees or collection actions. It is my responsibility to be informed of my insurance benefits, limitations, and exclusions. I have read and agreed to all terms above.

Signature _____ **Date** _____

TELL US YOUR PREFRENCES

Please circle which phrase best suites your personal preference

I know a great deal about my dental condition		I know very little about my dental condition
I like to be presented with fewer options		I like to be presented with more options
I tend to look at the details		I tend to look at the bigger picture
I prefer lasting solutions that may cost more		I prefer temporary solutions that cost less
I prefer to talk in technical terms		I prefer to talk in non technical terms
My insurance determines the extent of my care		I determine the extent of my care
I prefer to wait until I must act		I prefer a preventative approach
I rely on self maintenance		I rely more on professional maintenance
I like newer, more modern techniques		I prefer tried and true methods
I favor a treatment oriented approach to disease		I prefer a cause oriented approach to disease
I prefer high tech health care		I prefer high touch health care
I prefer an authoritarian doctor/hygienist who tells me what I need		I prefer a consultative doctor/hygienist who empowers my autonomy
I prefer to make lifestyle changes		I prefer clinical cures

In order of importance, I consider the following benefits of dental health (Please rank 1 (top importance) to 7 (least importance).

_____Comfort _____ Health _____ Longevity _____ Function _____ Appearance _____ Peace of Mind _____ Other

In order of importance, I consider the following costs regarding dental care (Please rank 1 (top importance) to 7 (least importance).

_____Money _____ Fear _____ Anxiety _____ Physical Discomfort _____ Time _____ Effort _____ Other

Signature _____ Date _____