

## 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 \_\_\_\_\_

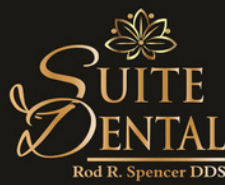
May we text you? ☐ Yes ☐ No

May we email you? ☐ Yes ☐ No

\*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		YES	NO		YES	NO
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion history	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen, ibuprofen, aspirin use	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/tumor	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Pre medications required by doctor	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>			
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			
Special diet	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>			
Taking allergy medication	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Taking heart medication	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve problem	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes or other STI	<input type="checkbox"/>	<input type="checkbox"/>			
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>			
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>			

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

	YES	NO
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure Medication	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, orinase, or similar drugs	<input type="checkbox"/>	<input type="checkbox"/>
Asprin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous drugs	<input type="checkbox"/>	<input type="checkbox"/>

Do you use tobacco?

	YES	NO
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Vaping	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine Pouches	<input type="checkbox"/>	<input type="checkbox"/>

If so, how much? \_\_\_\_\_

Do you drink alcohol?

	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

If so, how much? \_\_\_\_\_

If you marked YES to DIABETES

	YES	NO
Urinate more than 6x a day	<input type="checkbox"/>	<input type="checkbox"/>
Constantly thirsty or dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>

## HEALTH HISTORY FORM CONTINUED

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

	YES	NO
Local anesthetic (Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs, barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>

(If yes, please list ): \_\_\_\_\_

### Women

	YES	NO
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, expected delivery date? \_\_\_\_\_

Please list any other medication or condition not listed:

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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

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- 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 PREFERENCES

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 \_\_\_\_\_