Parkview Dental • 4895 S Higley Rd STE 101 • Gilbert AZ 85298 • 480-818-9016 • info@parkviewdentalAZ.com

New Patient Intake Form

Name:_____ Birthdate:_____
Address:_____ City:_____ State:_____ Zip:_____
Home phone:_____ Cell phone:_____ Email:_____
Sex: ☐ M ☐ F ☐ Other Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnership
☐ Widowed Employer or School:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Spouse, partner or parent name: _____
Person to contact in case of an emergency:_____ Phone:_____

How did you learn about our practice or whom may we thank for referring you? _____
Who is responsible for your account and payment? (if different from previous listing or self): _____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Email:_____ Birthdate:_____

Dental Insurance
Insurance company:_____ Phone # _____
Subscriber's Social Security #_____ Group #_____ ID # _____
Address:_____ City:_____ State:_____ Zip:_____
How much is your deductible?_____ How much have you used?_____ What is your annual maximum benefit? _____
Whose name is this insurance under? _____
Employer offering this insurance?_____ Phone:_____
Address:_____ City:_____ State:_____ Zip: _____

Secondary Dental Insurance
Insurance company:_____ Phone # _____
Subscriber's Social Security #_____ Group #_____ ID # _____
Address:_____ City:_____ State:_____ Zip:_____
Subscriber Name? _____
Subscriber DOB _____
Employer offering this insurance?_____ Phone:_____
Address:_____ City:_____ State:_____ Zip: _____

Dental History
Reason for today's visit: _____
What should we know about your dental preferences???_____
_____

Date of last dental care visit:
Date of last dental Xrays:_____
Former dentist's name:_____ Phone:_____

Check if you have any problem with the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between certain teeth
- ❑ Grinding teeth

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- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to any of the following: cold, hot, sweets
- ❑ Sensitivity when biting
- ❑ Sores or growth in your mouth

How often do you floss?_____ How often do you brush? _____

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Medical History

Your physician:_____Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"?

…….. ☐ Yes ☐ No

Have you had any serious illnesses or operations?..... ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a blood transfusion?..... ☐ Yes ☐ No

If yes, give approximate dates: _____

Women: are you pregnant?

…… ☐ Yes ☐ No

Are you nursing?..... ☐ Yes ☐ No

Are you taking birth control?..... ☐ Yes ☐ No

Check if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints, pins, etc.
- ❑ Asthma
- ❑ Bleeding abnormally
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV AIDS
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid problems
- ❑ Tobacco use
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

List medications you are currently taking and the correlating diagnosis:

Medication	Diagnosis

Please list any allergies you may have:

Allergy	**Allergy**

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

Patient or Guardian Signature *Date*