New Patient Intake Form

Personal Information

Please provide the information below.

First name

Preferred name

Title

Last name

Middle name

Gender

Birthdate

Email

Cell phone

Home phone

Work phone

- [ ] I want to receive text message and email reminders for my appointments

Address 1

Address 2

City

Province

Postal code

Country

Emergency contact name

Emergency phone

How did you hear about us?

Additional details

Medical Conditions

Please select all the medical conditions you have from the list below. If you have a medical condition or a concern not listed, please specify it in the additional details.

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease

- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Circulation Problems
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head or Neck Injuries
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pace Maker
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] High Blood Pressure
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Low blood pressure
- [ ] Lung Disease
- [ ] Mental/Nervous Disorder
- [ ] Organ/Medical Transplant
- [ ] Sickle Cell Disease
- [ ] Sinus problems
- [ ] Stroke
- [ ] Tuberculosis

Additional details

Primary Insurance

Insurance carrier name

Policy #

Subscriber #

Subscriber first name

Subscriber last name

Relationship to subscriber

- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Common Law Spouse
- [ ] Other

Subscriber birthdate

Additional details

Secondary Insurance

Insurance carrier name

Policy #

Subscriber #

Subscriber first name

Subscriber last name

Relationship to subscriber

Subscriber birthdate

- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Common Law Spouse
- [ ] Other

Additional details

Allergies

Please select all the allergies you have from the list below. If you have an allergy or a concern not listed, please specify it in the additional details.

- [ ] Acetaminophen
- [ ] Amoxicillin
- [ ] Aspirin
- [ ] Codeine
- [ ] Contact Dermatitis
- [ ] Environmental
- [ ] Erythromycin
- [ ] Fragrances
- [ ] Ibuprofen
- [ ] Latex
- [ ] Local Anesthetic
- [ ] Mercury
- [ ] Metal
- [ ] Morphine
- [ ] Penicillin
- [ ] PenV
- [ ] Sulpha
- [ ] Tetracycline

Additional details

Medications

Please add all the medications you currently take for your medical conditions. If you are taking a medicine that is not listed, please specify it in the additional details.

- [ ] Acetaminophen
- [ ] Amoxicillin
- [ ] Augmentin
- [ ] Augmentin 500
- [ ] Azithromycin
- [ ] Clindamycin
- [ ] Ibuprofen
- [ ] Other (Please add details in notes)
- [ ] Percocet
- [ ] Peridex
- [ ] Toradol
- [ ] Tylenol 3

Additional details

ASSIGNMENT OF INSURANCE

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I hereby assign my benefits payable from claims submitted to La Perle Dental Centre and authorize payment to them.

I authorize La Perle Dental Centre to speak with a plan administrator with my dental benefits plan in regards to any information contained in claims submitted.

CONSENT

Dr. Jain, Dr. Marshall & Associates would like all patients to understand the risks and benefits of dental treatment. At this time **I give consent** to examination and possible treatment including, but not limited to, fillings, bridges, crowns, extractions, root canals, local anesthetic and others. **All treatment will be discussed before any work is performed.**

Print name

Today's date