

Dental Patients Intake Form

Location: _____

Date: _____

Form #: _____

First Name	Last Name	Nationality	Phone #
DOB	Age	Gender	ID#:

Overall Health Questions	Yes	No	Medical History	Dental Exam\ Triage										
Are you in Good General Health			List All Current Medication:	Chief Complaint:										
Have you been evaluated by SAMS medical Team?														
Have you been evaluated by SAMS Dental Team?														
Medical Questions	Yes	No	List All Known Allergies:	Dental Diagnosis/ Findings										
Heart Disease?														
Pulmonary/ Lung Disease (Emphysema, COPD, etc.)			Any Other Medical Issue?	<table border="1"> <tr> <th colspan="2">Patient Consented to treatment?</th> </tr> <tr> <td>Yes</td> <td>No Patient declined Tx and Dismissed</td> </tr> </table>	Patient Consented to treatment?		Yes	No Patient declined Tx and Dismissed						
Patient Consented to treatment?														
Yes	No Patient declined Tx and Dismissed													
Kidney Disease (kidney stone, blood in Urine etc.)														
GI Disease (Acid reflux, constipation, diarrhea..)														
Neurologic (Stroke, Seizures, Dementia, etc.)														
Psychological														
Liver disease?			BP: _____ Pulse: _____	<table border="1"> <tr> <th colspan="5">Treatment Area</th> </tr> <tr> <td>GP</td> <td>OS</td> <td>Pedo</td> <td>Perio</td> <td>Hygiene</td> </tr> </table>	Treatment Area					GP	OS	Pedo	Perio	Hygiene
Treatment Area														
GP	OS	Pedo	Perio	Hygiene										
Do you Smoke														
Do you consume Alcoholic beverages														
Female Patient are you pregnant?														
Female Patient are you currently breastfeeding?														
Dental Questionnaire	Yes	No												
Do you have dental Pain?														
Do you brush your teeth Daily?														
Do you get routine dental care?														

Summary Of Care

Dental chart showing tooth positions 1-16 and 32-17. Labels A-J and T-K are placed below the teeth. 'RIGHT' is on the left side and 'LEFT' is on the right side. 'Lingual' is labeled between the top and bottom rows of teeth.

Preventive	
Cancer Screening	
Fluoride	
Smoke Cessation	
Diet Counseling	
Oral Hygiene instructions	
Hygiene	
Full Mouth Debridement	
Scaling/ Root planning	
Adult Prophy	
Child Prophy	

Symbol	X	P	Q	C	E	?
Procedure	Extraction	Pulpotomy	Crown	Restoration	Endo/ RCT	Other (specify)
Tally						

RX: _____

Additional Treatment Notes
Anesthetic: _____

Follow Up care/ Referral				
GP	OS OR	Pedo OR	Medical Consult	Other

Dr. Name & Specialty : _____

