CLIENT INTAKE FORM

Name _____ DOB _____ Date _____

Address _____

Email _____

Emergency Contact _____ Phone _____

**Please answer the questions below.

Insurance _____ Policy # _____ Group # _____

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

Insurance _____ 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

**Please mark any of the following conditions you may currently have.

- 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
- 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
- Jaundice
- Liver trouble
- Neurological disease
- Pacemaker
- Pre medications required by doctor
- Respiratory disease
- Rheumatic fever
- Seizure
- Severe headaches
- Shortness of breath
- Sinus problems
- Skin rashes
- Special diet
- Stroke
- Taking allergy medication
- Taking heart medication
- Thyroid problems
- Tuberculosis
- Ulcers
- Weight gain or loss

If you marked YES to DIABETES

- Urinate more than 6x a day
- Constantly thirsty or dry mouth
- Family history of diabetes

- Do you use tabacco?
  - If so, how much? _____
    - Cigarettes
    - Vaping
    - Nicotine Pouches
- Do you drink alcohol?
  - If so, how much? _____

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

- 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

Please list any other mediation or condition not listed: _____

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

- Local anesthetic (Novocain)
- Penicillin or other antibiotics (If yes, please list): _____
- Sulfa drugs, barbiturates, sedatives, or sleeping pills
- Aspirin, Acetaminophen, or Ibuprofen
- Codeine, Demerol, or other nercotics
- Reaction to metals
- Latex or rubber

Women

- Are you taking contraceptives or other hormones?
- Are you pregnant
- If yes, expected delivery date? _____
- Are you nursing?
- Have you reached menopause?

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.

Signature _____ Date _____

SUITE DENTAL
Rod R. Spencer DDS

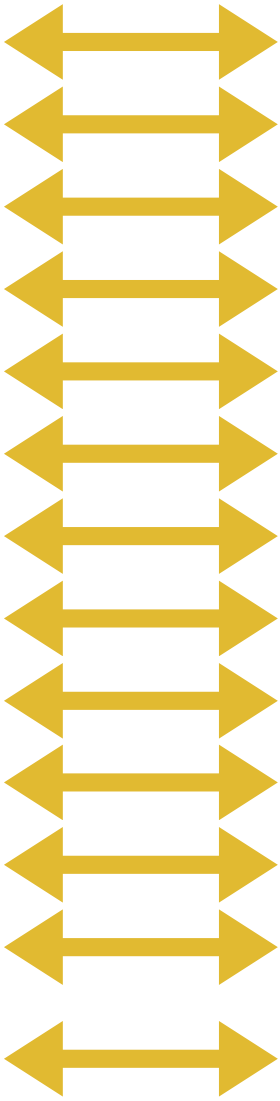
FINANCIAL AGREEMENT FORM

- 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

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 pref 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** _____