



Date: _____

James P. Klinger, D.D.S.

Dental Intake Form

Welcome! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

PATIENT INFORMATION:

_____ Preferred name/pronouns: _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: Male Female
SSN: _____ - _____ - _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Ok receiving confirmation text messages? Yes or No

Home Phone #: _____ Work Phone #: _____

Email Address: _____ Employer or School : _____

Spouse, partner, or parent name: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Who is responsible for your account and payment? _____ or SELF

Date of Birth: _____ Social Security#: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Email Address: _____ Employer: _____

Whom may we thank for referring you? _____

DENTAL INSURANCE:

Primary Dental Insurance

Insurance Company: _____ Ins. Phone #: _____

Subscriber's Name: _____ Relation to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

ID#: _____ Group #: _____ Group name: _____

Ins. Claims Address: _____ City: _____ State: _____ Zip: _____

Employer Offering Ins.: _____ Phone #: _____

DENTAL INSURANCE CONTINUED:

Secondary Dental Insurance

Insurance Company: _____ Ins. Phone #: _____
Subscriber's Name: _____ Relation to Patient: _____
Subscriber's Date of Birth: _____ Subscriber's SSN: _____
ID#: _____ Group #: _____ Group name: _____
Ins. Claims Address: _____ City: _____ State: _____ Zip: _____
Employer Offering Ins.: _____ Phone #: _____

DENTAL HISTORY:

Reason for today's visit: _____
Date of last dental visit: _____ Date of last dental x-ray: _____
Former dentist's name/office: _____ Phone: _____

Check if you have a history of any of the following:

- | | |
|---------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Periodontal treatment or disease |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sensitivity to hot, cold, and/or sweets |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Excessive bleeding after/during dental treatment | <input type="checkbox"/> Sores or growths in mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Loose teeth or broken fillings | _____ |

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

Are you happy with your smile? Yes or No Why? _____

Would you be interested in any of the following:

- | | |
|-----------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Orthodontics (Invisalign/Braces) | <input type="checkbox"/> Cosmetic treatment (Crowns/Bridges/Veneers) |
| <input type="checkbox"/> Whitening | <input type="checkbox"/> Implants |
| | <input type="checkbox"/> Dentures or Partial Dentures |
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To the best of my knowledge, the information above is correct.

I understand my dental insurance policy is a contract between myself, my employer, and the insurance company. Klinger Family Dentistry is not a party in that contract, therefore the insurance company has no obligations to our office. All charges incurred are my responsibility, regardless of insurance coverage.

I authorize dental staff at Klinger Family Dentistry to perform any necessary dental services on myself or my dependant with informed consent.

Signature _____ Date: _____