James P. Klinger, D.D.S.   Kole J. Kleinrichert, D.M.D

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:

Date:__________________

____ 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, caretaker, or parent name (circle):____

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:_______________

How did you hear about us? ☐ Internet Search (google, yelp, etc.) ☐ Social Media

☐ Doctor Referral: _____________ ☐ Peer/ Family Referral:_____________ ☐ Other:____________

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:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clenching or grinding
- ☐ Clicking or popping jaw
- ☐ Dry Mouth
- ☐ Excessive bleeding after/during dental treatment
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment or disease
- ☐ Sensitivity to hot, cold, and/or sweets
- ☐ Sensitivity when biting
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Sores or growths in mouth
- ☐ Other: _______________________ _____________________________

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:

- ☐ Orthodontics (Invisalign/Braces)
- ☐ Whitening
- ☐ Cosmetic treatment (Crowns/Bridges/Veneers)
- ☐ Implants
- ☐ Dentures or Partial Dentures
- ☐ Extractions

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:______________________