APPENDIX

Standardized Intake Form

Demographic Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. Our school does not use this information to discriminate.

DATE (MONTH/DAY/YEAR): ___/___/____ DATE OF BIRTH: ___/___/_____ SEX: M / F / TRANSGENDER SSN: _____-____-_____

Mr / Mrs / Miss / Ms / Dr / Fr / Rev Sr / Jr/ I / II / III

PREFIX LAST FIRST SUFFIX

ADDRESS CITY STATE ZIP

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE ZIP

( ) - ( ) - ( ) - @

HOME PHONE CELL PHONE WORK PHONE E-MAIL ADDRESS

Emergency Contact: _____ Relationship: _____ Home phone: (___) ___-____ Cell phone: (___) ___-_____

If the Child is a Minor:

LAST NAME OF PARENT OR GUARDIAN FIRST NAME OF PARENT OR GUARDIAN

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE ZIP

( ) - ( ) - ( ) - @

HOME PHONE CELL PHONE WORK PHONE E-MAIL ADDRESS

Occupation: _____ Employer: _____

Do you have dental insurance? YES NO If yes, who is your provider?

PRIMARY CARRIER POLICY HOLDER EMPLOYER POLICY/GROUP NUMBER SUBSCRIBER I.D.

SECONDARY CARRIER POLICY HOLDER EMPLOYER POLICY/GROUP NUMBER SUBSCRIBER I.D.

TERTIARY CARRIER POLICY HOLDER EMPLOYER POLICY/GROUP NUMBER SUBSCRIBER I.D.

Do you have medical insurance? YES NO If yes, who is your provider?

PRIMARY CARRIER POLICY HOLDER EMPLOYER POLICY/GROUP NUMBER SUBSCRIBER I.D.

SECONDARY CARRIER POLICY HOLDER EMPLOYER POLICY/GROUP NUMBER SUBSCRIBER I.D.

TERTIARY CARRIER POLICY HOLDER EMPLOYER POLICY/GROUP NUMBER SUBSCRIBER I.D.

Physician(s) Name, Address, and Phone Number:

Primary Care Physician: _____
Name Street City Phone

Cardiologist: _____
Name Street City Phone

Orthopedist: _____
Name Street City Phone

Other: _____
Specialty Name Street City Phone

Are you providing any additional documentation that you would like included in your patient record? YES NO
If yes, what documentation: ___Radiographs ___Medical information ___Referral letter Other (Specify):_____

Were you referred to this clinic? YES NO
If yes, who referred you: ___Dentist ___Doctor ___Family ___Friend ___Other (Specify):_____

Do you have any special needs/accommodations? YES NO If yes, what is your special need/accommodation?
____Blind/Visually impaired ____Deaf/Hearing impaired ____Require wheelchair ____Require sign language interpreter
____Require language interpreter (Specify): _____

If you were not born in the United States, what is your country of origin? ___Canada ___Mexico ___Other (Specify):_____
If you live in the United States but were not born here, how long have you lived here? _____ years _____ months
If your primary spoken language is not English, which language are you most comfortable speaking?
☐ Spanish ☐ Portuguese ☐ Cantonese ☐ Mandarin ☐ French ☐ Russian ☐ Italian ☐ Haitian Creole
☐ Other (Specify): _____ I require a language interpreter (Specify language): _____

ETHNIC CATEGORY:
___Hispanic or Latino
___Not Hispanic or Latino

RACE: Select ALL the groups with whom you identify:
___American Indian or Alaska Native
___Asian
___Black or African American
___Native Hawaiian or Other Pacific Islander
___White

What is your highest education level?
___Elementary school
___Middle school
___Some high school
___High school graduate
___Some college
___Associate's degree
___Bachelor's degree
___Master's degree
___Doctoral degree

What is your total household income?
☐ Less than $14,999
☐ $15,000 to $29,999
☐ $30,000 to $44,999
☐ $45,000 to $59,999
☐ $60,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 to $249,999
☐ $250,000 or more

What is your household size?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ more than 8

APPENDIX *(continued)*

Medical History

Name:_____ Height_____ Weight_____
Last First MI

Blood Pressure: _____/_____ **Date:** _____ **Pulse:** _____ **Date:** _____ *(Staff will measure both)*

PLEASE CIRCLE YOUR RESPONSES (*YES, NO, DK (DON'T KNOW)*) TO INDICATE IF YOU HAVE, HAVE NOT, OR DO NOT KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS.

Do you have any of the following diseases or problems?

YES NO DK Active Tuberculosis
YES NO DK Persistent cough greater than 3 weeks in duration
YES NO DK Cough that produces blood
YES NO DK Been exposed to anyone with Tuberculosis

If you answered yes to any of the 4 items above, please stop. Talk to your student dentist or someone at the reception desk.

What is your impression of your health? **EXCELLENT GOOD FAIR POOR** Date of last physical examination (Month/Year): ____/_____

YES NO DK Are you now, or have you been in the past year, under the care of a physician? If yes, what is/are the condition(s) being treated?_____

YES NO DK Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____

YES NO DK Have you had an organ transplant? If yes, please specify: **HEART KIDNEY LIVER LUNG OTHER (Specify):**_____

YES NO DK Have you had open heart surgery? If yes, please specify: **VALVE BYPASS (CABG) OTHER (Specify):**_____
If yes, when was your heart surgery (Year)? _____
If yes, have you had any complications within the last 2 years? **YES NO DK** If yes, please specify: _____

YES NO DK Have you had an orthopedic total joint (e.g., hip, knee, elbow, finger) replacement?
If yes, what joint was replaced? **ANKLE ELBOW FINGER HIP KNEE SHOULDER OTHER (Specify):**_____
If yes, when was the joint replaced (Month/Year)? _____
If yes, have you had any complications within the last 2 years? **YES NO DK** If yes, please specify: _____

YES NO DK Have you ever had any radiation therapy or chemotherapy for a growth, tumor, or other condition?
Radiation: Explain:_____
Chemotherapy: Explain:_____

YES NO DK In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)? Please specify:

Medication	**Dosage/Frequency**	**Length of Period Taken** *(Days, Weeks, Months, Years)*	**If no longer taking, when was the medication discontinued?**

Have you taken, are you taking, or are you scheduled to begin taking?

YES NO DK Oral bisphosphonates (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid))?

If yes, what drug, dose, and frequency?

☐ Fosamax: Dose: _____ Frequency: _____
☐ Fosamax Plus D: Dose: _____ Frequency: _____
☐ Didronel: Dose: _____ Frequency: _____
☐ Boniva: Dose: _____ Frequency: _____
☐ Actonel: Dose: _____ Frequency: _____
☐ Skelid: Dose: _____ Frequency: _____

If yes, what for?

☐ Osteoporosis
☐ Paget's disease
☐ Other (Specify): _____

If yes, when?

☐ Past (Specify MONTH/YEAR started and how long taken): _____
☐ Current (Specify MONTH/YEAR started): _____
☐ Scheduled (Specify MONTH/YEAR treatment will begin): _____

Have you taken, are you taking, or are you scheduled to begin taking?

YES NO DK Intravenous bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia), or Zoledronic Acid (Reclast, Zometa))?

If yes, what drug, dose and frequency?

☐ Bonefos: Dose: _____ Frequency: _____
☐ Aredia: Dose: _____ Frequency: _____
☐ Reclast: Dose: _____ Frequency: _____
☐ Zometa: Dose: _____ Frequency: _____

If yes, what for?

☐ Bone pain
☐ Osteoporosis
☐ Hypercalcemia
☐ Skeletal complications from Paget's disease
☐ Skeletal complications from multiple myeloma
☐ Skeletal complications from metastatic cancer

If yes, when?

☐ Past (Specify when started and how long taken): _____
☐ Current (Specify when started): _____
☐ Scheduled (Specify when treatment will begin): _____

YES NO DK Do you use or have you used tobacco (smoking, snuff, chew, bidis)? **NEVER PAST CURRENTLY**

If yes, please specify type: **SMOKING SNUFF CHEW BIDIS**

If yes, please specify amount per day: _____ For how many years: _____

If yes, how interested are you in stopping? **VERY SOMEWHAT NOT INTERESTED**

YES NO DK Do you drink alcoholic beverages?

If yes, how many drinks did you drink in the last 24 hours? _____

If yes, how many drinks do you typically drink in a week? _____

If yes, are you alcohol dependent? **YES NO DK**

If yes, how long have you been alcohol dependent (months)? _____

If yes, have you received treatment? **YES NO**

YES NO DK Do you use prescription or street drugs or other substances for recreational purposes?

If yes, please indicated drugs used:

COCAINE HEROIN OXYCONTIN METHAMPHETAMINE ECSTASY MARIJUANA OTHER (Specify)_____

If yes, how often do you use? _____

If yes, are you drug dependent? **YES NO DK**

If yes, how long have you been drug dependent (months)? _____

If yes, have you received treatment? **YES NO**

WOMEN ONLY:

YES NO DK Are you pregnant? If yes, number of weeks: _____

YES NO Are you trying to become pregnant?

YES NO DK Are you nursing?

YES NO DK Are you taking birth control pills, fertility drugs, or hormonal replacement?

(Specify): **BIRTH CONTROL FERTILITY DRUGS HORMONAL REPLACEMENT**

YES NO DK **Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural, or herbal)? If yes, please specify medication(s), dosage, and frequency:**

Medication *Prescription or Over the Counter*	**Dosage/Frequency**	**Supplements** *Diet supplements, vitamins (natural or herbal)*	**Dosage/Frequency**
ASPIRIN YES NO	Last Dose:		

APPENDIX *(continued)*

ALLERGIES: Are you allergic to or have you had a reaction to any of the following?
For yes responses, please specify type of reaction:

YES NO DK	Local anesthetics (Novocaine/Epinephrine)	Reaction: _____
YES NO DK	Penicillin	Reaction: _____
YES NO DK	Sulfa drugs	Reaction: _____
YES NO DK	Other antibiotics (Specify): _____	Reaction: _____
YES NO DK	Codeine or other narcotics	Reaction: _____
YES NO DK	Aspirin	Reaction: _____
YES NO DK	Barbiturates (sedatives or sleeping pills)	Reaction: _____
YES NO DK	Hay fever/seasonal (allergic rhinitis)	Reaction: _____
YES NO DK	Animals	Reaction: _____
YES NO DK	Metals/Jewelry (nickel/chrome)	Reaction: _____
YES NO DK	Food (Specify): _____	Reaction: _____
YES NO DK	Iodine	Reaction: _____
YES NO DK	Latex (rubber)	Reaction: _____
YES NO DK	Other/Other Medication(s) (Specify): _____	Reaction: _____

MEDICAL CONDITIONS: Do you have or have you had any of the following diseases, problems, or symptoms?

YES NO DK *Heart/Blood Pressure problem*
If yes, please specify:
- ☐ Rheumatic fever/Rheumatic heart disease
- ☐ Infective endocarditis
- ☐ Artificial heart valves
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Angina (chest pain): How often?_____
- ☐ Heart attack: Date(s)_____
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Arteriosclerosis
- ☐ Palpitations
- ☐ Arrhythmia (irregular heart beat)
- ☐ Shortness of breath
- ☐ Swelling of the ankles
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Sleep on two or more pillows
- ☐ Other (Specify): _____

YES NO DK *Respiratory/Lung problem*
If yes, please specify:
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Tuberculosis
- ☐ Sarcoidosis
- ☐ Pneumonia
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Other (Specify): _____

YES NO DK *Diabetes/Endocrine disorder*
If yes, please specify:
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
  - ☐ Gestational
- ☐ Thyroid problems
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism
- ☐ Adrenal gland disorder
- ☐ Other (Specify): _____

YES NO DK *Kidney/Prostate disorder*
If yes, please specify:
- ☐ Kidney stones
- ☐ Renal failure/insufficiency
- ☐ Dialysis
- ☐ Prostate
- ☐ Frequent urination
- ☐ Other (Specify): _____

YES NO DK *Cancer or Tumors*
If yes, please specify:
- ☐ Malignant
  Location: _____
- ☐ Benign
  Location: _____

YES NO DK *Neurologic/Nerve problem*
If yes, please specify:
- ☐ Stroke
- ☐ TIA (transient ischemic attack)
- ☐ Seizures/Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies
- ☐ Dementia/Alzheimer's (memory loss)
- ☐ Headache
- ☐ Fainting or dizzy spells
- ☐ Weakness
- ☐ Feeling of tingling or numbness
- ☐ Psychiatric disease/Mental health disorder
  - ☐ Bipolar/Manic depression
  - ☐ Schizophrenia
  - ☐ Depression
- ☐ Post traumatic stress disorder
- ☐ Obsessive/compulsive disorder
- ☐ ADD/ADHD (attention deficit disorder)
- ☐ Feelings of anxiety
- ☐ Feelings of depression
- ☐ Other (Specify): _____

YES NO DK *Blood/Hematologic disorder*
If yes, please specify:
- ☐ Anemia
- ☐ Thalassemia
- ☐ Sickle cell disease
- ☐ Sickle cell trait
- ☐ Deep vein thrombosis
- ☐ Bruise easily
- ☐ Leukemia
  - ☐ Acute lymphocytic
  - ☐ Chronic lymphocytic
  - ☐ Acute myelogenous
  - ☐ Chronic myelogenous
- ☐ Lymphoma
  - ☐ Hodgkin's
  - ☐ Non-Hodgkin's
- ☐ Multiple myeloma
- ☐ Bleeding disorders
  - ☐ Hemophilia
  - ☐ Von Willebrand's
  - ☐ Drug induced
  - ☐ Idiopathic thrombocytopenic purpura
  - ☐ Other (Specify): _____
- ☐ Other (Specify): _____

YES NO DK *Stomach/Intestine/Liver disorder*
If yes, please specify:
- ☐ Cirrhosis/Chronic hepatitis
- ☐ Jaundice (skin/eyes turn yellow)
- ☐ Hepatitis
  - ☐ A
  - ☐ B
  - ☐ C
  - ☐ D
  - ☐ Other (Specify): _____
- ☐ Heartburn
- ☐ Acid reflux (GERDS)
- ☐ Gall stones
- ☐ Ulcers
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome
- ☐ Other (Specify): _____

YES NO DK *Muscle/Bone/Connective Tissue disorder*
If yes, please specify:
- ☐ Arthritis
  - ☐ Rheumatoid
  - ☐ Osteoarthritis
  - ☐ Other (specify): _____
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Lupus
- ☐ Scleroderma
- ☐ Fibromyalgia
- ☐ Other (Specify): _____

YES NO DK *Infectious disease*
If yes, please specify:
- ☐ HIV
- ☐ AIDS
- ☐ MRSA
- ☐ STD (sexually transmitted disease)
  - ☐ Syphilis
  - ☐ Gonorrhea
  - ☐ Chlamydia
  - ☐ Genital herpes
  - ☐ Human papillomavirus
- ☐ Cold sores
- ☐ Mononucleosis
- ☐ Other (Specify): _____

YES NO DK *Head/eye/ear/nose/throat problem*
If yes, please specify:
- ☐ Vision problems
- ☐ Wear contact lenses
- ☐ Glaucoma
- ☐ Cataract
- ☐ Hearing impairment
- ☐ Other (Specify): _____

YES NO DK ***Dermatologic/Skin problem***
If yes, please specify:
☐ Psoriasis
☐ Other (Specify): _____

YES NO DK ***Eating disorder***
If yes, please specify:
☐ Bulimia
☐ Anorexia
☐ Other (Specify): _____

YES NO DK ***Immunosuppression***

YES NO DK ***Family history of diabetes***

YES NO DK ***Family history of heart disease***

YES NO DK ***Family history of cancer or tumors***

YES NO DK ***Do you feel safe at home?***

YES NO DK ***Do you have any other problem, disease, or condition not listed above?***
If yes, please specify: _____

_____

Dental History

What is the reason for your dental visit today? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**
How would you describe your current dental problem?_____
Date of your last dental visit (Month/Year): ____/_____
What was done at that time? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**
Date of your last dental exam (Month/Year): ____/_____ Date of your last dental x-rays (Month/Year): ____/_____
Date of your last dental cleaning (Month/Year): ____/_____

YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, specify where? **UPPER RIGHT UPPER LEFT LOWER RIGHT LOWER LEFT**

YES NO DK Are your teeth sensitive to cold, hot, sweets, or pressure? (Specify): **COLD HOT SWEETS PRESSURE**
If yes, specify where? **UPPER RIGHT UPPER LEFT LOWER RIGHT LOWER LEFT**

YES NO DK Do you have problems with eating (trouble chewing, vomiting, etc.)? (Specify): **TROUBLE CHEWING VOMITING OTHER**

YES NO DK Do you have swelling in or around your mouth, face, or neck? (Specify): **MOUTH FACE NECK**

YES NO DK Do you have loose teeth?

YES NO DK Do you have bad breath, metallic taste, or unpleasant taste?
(Specify): **BAD BREATH METALLIC TASTE UNPLEASANT TASTE**

YES NO DK Do you have headaches, earaches, or neck pains? (Specify): **HEADACHES EARACHES NECK PAINS**

YES NO DK Do you have any clicking, popping, discomfort, or limited opening in the jaw?
(Specify): **CLICKING POPPING DISCOMFORT LIMITED OPENING**

YES NO DK Do you clench, brux, or grind your teeth? (Specify): **CLENCH BRUX/GRIND BOTH**

YES NO DK Do you have sores or ulcers in your mouth?

YES NO DK Have you lost any teeth other than through extractions?

YES NO DK Do you have a history of tooth extraction or oral surgery (implants, cosmetic procedures, or TMJ surgery)?
(Specify): **EXTRACTIONS IMPLANTS FACIAL COSMETICS TMJ SURGERY**

YES NO DK Have you had any periodontal (gum) treatments?

YES NO DK Do you have bridges or wear dentures or partials? (Specify): **BRIDGES DENTURES PARTIALS**

YES NO DK Have you ever had root canal treatment?

YES NO DK Have you ever had orthodontic (braces) treatment?

YES NO DK Have you had a local anesthetic (Novocaine) for dental purposes?
If yes, have you experienced any problems? **YES NO** If yes, please specify: _____

YES NO DK Have you had any problems associated with previous dental treatment?
If yes, please specify: _____

How often do you brush your teeth?
NEVER SOMETIMES ONCE A DAY TWICE A DAY MORE THAN TWICE A DAY

How often do you floss your teeth?
NEVER SOMETIMES ONCE A WEEK ONCE A DAY MORE THAN ONCE A DAY

Do your gums bleed when you brush or floss?
NEVER SOMETIMES ALWAYS

YES NO DK Do you have any obstacles to cleaning or caring for your teeth?

YES NO DK Does food or floss catch between your teeth?

YES NO DK Do you participate in active recreational activities or sports?

YES NO DK Have you ever had a serious injury to your head or mouth?

YES NO DK Are you unhappy with your smile or the appearance of your teeth?

YES NO DK Are you worried about losing your teeth?

Rate your fear of dental treatment on a scale of 0 (no fear) to 10 (extreme fear): _____
Please state any questions or concerns about dentistry or your dental health: _____

Did an interpreter help you with these forms? **YES NO**
If you are completing these forms for the patient, what is your relationship to the patient? **MOTHER FATHER GUARDIAN OTHER**
If you are completing these forms for the patient, what is your name? _____