Dental Clinic Intake Form for non-Mariam Clinic Patients

*** No children under the age of 16 are allowed in the dental clinic or waiting room***

Most procedures are performed free. Low cost root canals & crowns available, while dentures and partial plates are <u>not</u> available

$25 Administration fee payable at time of service

Patient name: _____ Age:____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____

Annual Household Income: _____No: Family Members: _____

Eligibility Requirements: 1. Copy of last year tax return include Schedule C if self employed

2. Two most recent paystubs for all working members of household

3. Copy of Medicaid/Medicare/Medical Insurance card

Mariam Clinic Patient ☐ Yes ☐ No Dental Insurance ☐ Yes ☐ No

Medical Insurance ☐ Yes ☐ No Medicaid ☐ Yes ☐ No Medicare: ☐ Yes ☐ No

Dental Issue to be treated: _____

Current Medications: _____

_____

Known Medication Allergies: _____

Date of Last Dental Exam: _____

Please fill out all 3 forms, attach eligibility requirement documents and mail it to address below. Please call (919) 824-4672 with any questions. **Incomplete applications will not be eligible for service nor will they be kept on file.**

Mariam Clinic Dental Program

4441-106 Six Forks Road #388

Raleigh, NC 27609

Patient Name:_____ Date:_____

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or after relevant information could result in serious patient drug instructions or death. The following questions must be answered honestly so that our office can provide you with the best possible care.

Please circle the correct responses.

- ☐ Have you ever been seriously ill since your last office visit?
  - ☐ Yes
  - ☐ No
- ☐ Have there been any changes in your medical history since your last office visit?
  If yes, please explain_____
  _____.
- ☐ Is a medical doctor currently treating you?
  - ☐ Yes
  - ☐ No
- ☐ Please provide your primary care physician's name and phone number.
  _____.
- ☐ Please list any medications (Prescription or Over-the-Counter)
  _____.
- ☐ Are you allergic to, or have you had unusual reactions to any of the following?
  Please check that all apply:
  - ☐ **Penicillin**
  - ☐ **Aspirin**
  - ☐ **Iodine**
  - ☐ **Codeine**
  - ☐ **Latex**
  - ☐ **Erythromycin**
  - ☐ **Sulfa Drugs**
  - ☐ **Barbiturates**
  - ☐ **No Known Allergies**
- ☐ **Please check the box if you have ever had or been told you have any of the following:**
  - ☐ **Heart Defect**
  - ☐ **Infective Endocarditis**
  - ☐ **High Blood Pressure**
  - ☐ **Low Blood Pressure**
  - ☐ **Diabetes**
  - ☐ **Heart Attack**
  - ☐ **Herpes**
  - ☐ **Hives/Skin Rash**
  - ☐ **Epilepsy**
  - ☐ **Seizures**
  - ☐ **Anemia**
  - ☐ **Depression**
  - ☐ **Deviated Septum**
  - ☐ **Arthritis**
  - ☐ **Pacemaker**
  - ☐ **Sinus Trouble**
  - ☐ **AIDS**
  - ☐ **Rheumatic Fever**
  - ☐ **Hepatitis**
  - ☐ **Tuberculosis**
  - ☐ **Stroke**
  - ☐ **Jaundice**
  - ☐ **Frequent Headaches**
  - ☐ **Asthma**
  - ☐ **Hay Fever**
  - ☐ **Venereal Disease**
  - ☐ **Active Infection**
  - ☐ **Swollen Neck Glands**
  - ☐ **Osteoporosis**
  - ☐ **Thyroid Problems**
  - ☐ **Other:**
    _____

8. **Have you ever taken a biophosphonate such as Fosamax, Actonel, or Boniva?**

- ☐ Yes
- ☐ No

Quality of Sleep:

9. **Have you been told you snore occasionally?**

- ☐ Yes
- ☐ No

10. **Do you wish you slept better and had more energy?**

- ☐ Yes
- ☐ No

11. **Have you been prescribed or do you use a CPAP?**

- ☐ Yes
- ☐ No

12. **Do you feel tired throughout the day?**

- ☐ Yes
- ☐ No

For women only: Women who taken oral contraceptives (birth control pills) should take extra precautions when taking antibiotics because antibiotics can cause failure of birth control pills, which can result in pregnancy.

13. **Are you pregnant or suspect that you may be pregnant**

- ☐ Yes
- ☐ No

14. **Are you taking oral contraceptives (birth control pills)?**

- ☐ Yes
- ☐ No

15. **If you use other types of birth control medications that are not pills (such as Depo shots), please list:**

_____

16. **My current dental goals are:**

- ☐ Whiter teeth
- ☐ Pain Free
- ☐ Straighter Teeth
- ☐ Healthier Gums
- ☐ Replace Missing Teeth
- ☐ Full Dentures
- ☐ Cavity Free
- ☐ Better Breath
- ☐ Less bleeding
- ☐ Decrease Sensitivity
- ☐ Partials
- ☐ Better Chewing
- ☐ Sedation Dentistry
- ☐ Stop Snoring

I have read through and understand the above questions. I have answered all of these questions truthfully and to the best of my ability and knowledge. I consent to the diagnostic procedures a dentistry necessary for proper dental care.

Patient Name: _____

Patient Signature: _____