Graham & McCabe
Family Dentistry

# Patient Intake Form

## Patient Information

Full Name: _____
Preferred Name: _____
Date of Birth: _____ Gender: _____

Address: _____
City / State / Zip: _____

Phone:
Mobile _____ Home _____ Work _____

Email: _____
Employer: _____
Marital Status: _____

**Preferred Method of Contact:**
☐ Call ☐ Text ☐ Email
Preferred Phone Number (if applicable): _____

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## Insurance Information

Do you have dental insurance?
☐ No
☐ Yes

If yes:
Insurance Company: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Relationship to Patient: _____
Member ID: _____
Group Number: _____

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## How Did You Hear About Us?

☐ Google ☐ Website ☐ social media ☐ Friend/Family
☐ Doctor Referral ☐ Other: _____

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**Responsible Party (if different)**

Name: _____
Relationship: _____
Phone: _____ Email: _____

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**Your Main Concern**

What brings you in today?

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**Dental & Oral Health**

**Dental Experience**

☐ Fear or anxiety about dental visits
☐ Previous negative dental experience
☐ Difficulty getting numb

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**Gums & Teeth**

☐ Bleeding gums
☐ History of gum disease
☐ Tooth sensitivity
☐ Food trapping

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**Bite & Jaw Health**

☐ Jaw pain, clicking, or popping
☐ Clenching or grinding
☐ Wear a nightguard
☐ Teeth shifting or wearing

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**Airway, Snoring & Sleep Health**

Do you currently:
☐ Snore

☐ Snore loudly (disturbs others)
☐ Wake up tired or unrefreshed
☐ Morning headaches or jaw soreness
☐ Wake up during the night
☐ Mouth breathe during sleep
☐ Difficulty breathing through your nose?

Has anyone told you that you:
☐ Stop breathing during sleep
☐ Gasp or choke at night?

Sleep apnea diagnosis:
☐ No ☐ Yes (☐ Mild ☐ Moderate ☐ Severe) ☐ Unsure.

If diagnosed, treatment:
☐ CPAP ☐ Oral appliance ☐ Surgery ☐ Not treating.

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**Medical Overview**

Are you currently taking prescription medications?
☐ No ☐ Yes → Please list: _____

Do you have any medication or substance allergies?
☐ No ☐ Yes → Please list: _____

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**Medical Conditions (Check all that apply)**

**Heart & Circulation**
☐ High blood pressure ☐ heart disease ☐ Stroke
☐ Arrhythmia ☐ Heart murmur ☐ Pacemaker

**Metabolic**
☐ Diabetes ☐ Thyroid ☐ High cholesterol

**Respiratory**
☐ Asthma ☐ Sleep apnea ☐ Sinus issues

**Digestive**
☐ Acid Reflux ☐ Digestive issues

**Neurologic**
☐ Headaches ☐ Seizures ☐ Dizziness

**Musculoskeletal / Autoimmune**
☐ Arthritis ☐ Autoimmune ☐ Joint replacement

**Other**
☐ Cancer ☐ Radiation ☐ Chemotherapy
☐ Hepatitis ☐ HIV ☐ TB ☐ HPV
☐ Pregnancy ☐ Nursing
☐ Anxiety ☐ Depression
☐ Bleeding disorder ☐ Easy bruising
☐ Allergies ☐ Chronic pain
☐ Other: _____

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**Additional Medical Information**

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**Tobacco & Nicotine Use**

☐ No
☐ Yes → ☐ Cigarettes ☐ Vape ☐ Smokeless ☐ Pouches ☐ Other

Frequency: ☐ Daily ☐ Occasional ☐ Social
Duration: ☐ <1 yr ☐ 1–5 yrs ☐ 5–10 yrs ☐ 10+ yrs

Former user? ☐ No ☐ Yes → Quit: _____

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**Smile Vision**

What do you love about your smile?

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What would you like to change?

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**Interested in:**
☐ Whitening ☐ Straightening ☐ Repairing wear
☐ Veneers ☐ Full smile makeover.

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**HIPAA Acknowledgment**

We respect your privacy. Your health information will be used for treatment, payment, and healthcare operations.

I acknowledge I have been offered a copy of the Notice of Privacy Practices.

☐ I consent to use/disclosure of my information as described.

Authorized contacts (optional):
Name: _____ Relationship: _____

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**Financial Policy**

Payment is due at the time services are rendered unless prior arrangements have been made.

We accept cash, check, and credit cards. Third-party financing must be arranged prior to treatment.

Graham & McCabe Family Dentistry is committed to providing the highest quality care. We are not in-network with many insurance plans due to limitations they place on treatment recommendations.

As a courtesy, we will file insurance claims on your behalf. However:

- Your insurance policy is a contract between you and your insurance company.
- You are ultimately responsible for all charges.
- Estimated coverage is not a guarantee of payment.

**Patient Responsibility:**

- Deductibles and estimated portions are due at time of service.
- You are responsible for understanding your benefits (maximums, waiting periods, exclusions)
- If insurance has not paid within 60 days, the balance becomes your responsibility.

**Payment Options:**
• 5% courtesy discount for payment in full (cash or check only)
• Payment by appointment (phased with treatment)
• 3-month payment plans with card on file (auto-charged, no reminders)
• Extended financing available through CareCredit.

**Additional Policies:**
• Returned checks are subject to a $25 fee
• We require 24-hour notice for cancellations
• Missed/late cancellations may result in a $50 fee.

We are happy to discuss any financial questions prior to treatment.

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**Patient Agreement & Signature**

I certify that the information provided is accurate and complete. I understand and agree with the financial policy and acknowledge my responsibility for payment.

Signature: _____
Printed Name: _____
Date: _____

Parent/Guardian (if applicable): _____

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