Dental Clinic Intake Form – Mariam Clinic

NO children under 16 years of age allowed in the dental clinic or waiting room

Fee Schedule

Procedure	Fee
Limited Exam	$75
Comprehensive Exam	$85
Bitewing X-rays	$58
Single x-ray	$27
Each additional x-ray	$22
Panoramic x-ray	$101
Prophylaxis	$77
Simple Extractions	$45
Surgical Extractions	$65
Impacted Extractions	$99
Root Canal	$550
Crowns	$795
Restorative Filling	$65 Each

Name: _____ Age: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____

Annual Household Income: _____ Number of Household Members: _____

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

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

Dental Issue to be treated: _____

_____

Date of Last Dental Exam: _____

Mail the following documents with your application (Incomplete applications will not be eligible for service, nor will they be kept on file)

#1. Last year tax return (1040), Sch C if self employed

#2 Two most recent paystubs for ALL working members of your household

#3 Copy of your Medical Insurance Card

Mariam Clinic Dental Program

4441-106 Six Forks Rd Ste 388

Raleigh NC 27609

919-824-4672

Patient Name:_____ **Date:**_____

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions 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 response.

1. Have you ever been seriously ill since your last office visit? ☐Yes ☐No
2. Have there been any changes in your medical history since your last office visits?

If yes, please explain:_____

3. Is a medical doctor currently treating you? ☐Yes ☐No
4. Please provide your primary care physician's name and phone number:

_____

5. Please list any medication (Prescription or Over-the-Counter)

_____

6. Are you allergic to, or have you had unusual reactions to any of the following?

Please check all that apply.

☐ Penicillin	☐ Codeine	☐ Sulfa Drugs
☐ Aspirin	☐ Latex	☐ Barbiturates
☐ Iodine	☐ Erythromycin	☐ No Known Allergies

7. Please check the box if you have ever had or been told you have any of the following:

Heart Defect	☐	AIDS	☐
Infective Endocarditis	☐	Rheumatic Fever	☐
High Blood Pressure	☐	Hepatitis	☐
Low Blood Pressure	☐	Tuberculosis	☐
Diabetes	☐	Stroke	☐
Heart Attack	☐	Jaundice	☐
Herpes	☐	Frequent Headaches	☐
Hives/Skin Rash	☐	Asthma	☐
Epilepsy	☐	Hay Fever	☐
Seizures	☐	Venereal Disease	☐
Anemia	☐	Kidney Disease	☐
Depression	☐	Active Infection	☐
Deviated Septum	☐	Swollen Neck Glands	☐
Arthritis	☐	Osteoporosis	☐
Pacemaker	☐	Thyroid Problems	☐
Sinus Trouble	☐		

Other: ☐ _____

8. Have you ever taken a biophosphenate such as Fosamax, Actonel of 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 take 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 and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge. I consent to the diagnostic procedures and dentistry necessary for proper dental care.

Patient Name: _____

Patient Signature: _____