Triax Dental (Michael D. Vaughan, DDS)
New Patient Intake Form

Version 4.1, Last update : March 9th, 2020

triaxDENTAL

PATIENT INFORMATION

*Patient name:			*Date of birth:	*Social Security #:	*Sex:
*Address:			*City:	*State:	*Zip:
*Ethnicity:	*Patient height:	*Patient weight:	*Home phone (or NA):	*Mobile phone (or NA):	
Reason for seeking treatment?			*E-mail:		

MEDICAL HISTORY (CHECK IF ANY OF THE FOLLOWING APPLIES OR ☐ CHECK HERE IF NO SIGNIFICANT MEDICAL FINDINGS)

☐ Cardiovascular Disease - Heart Attack, Angina, Atherosclerosis, Stroke (please circle)	☐ Arthritis	☐ Thyroid disorders
☐ History of infective endocarditis, artificial heart valves, heart defects (please circle)	☐ Osteoporosis	☐ Sleep apnea
☐ High blood pressure	☐ Respiratory problems - Emphysema, Bronchitis, COPD, Tuberculosis (please circle)	☐ Eating disorders
☐ Diabetes (Type I or II) HbA1C: %	☐ Asthma	☐ Cyclic vomiting syndrome
☐ Hepatitis or liver disease (If yes, list type)	☐ Seizures (If yes, list type and frequency)	☐ Cancer (If yes, list type and treatment)
☐ Kidney disorders	☐ Low blood pressure or syncope (please circle)	☐ Pregnant or nursing
☐ GERD or heartburn	☐ Intellectual or developmental disability	☐ Alcohol abuse
☐ Stomach ulcers	☐ Mental health disorders	☐ Drug abuse
☐ HIV or AIDS (If yes, please list meds)	☐ Anemia or sickle cell anemia (please circle)	☐ Tobacco use (please list type, amount per day and years of use
☐ Autoimmune disorders	☐ Bleeding disorders (If yes, list type)	

Please provide details about items checked above:

Do you have any disease, disorder, or complication not mentioned above?	Have there been any changes in your general health in the last year?

MEDICATIONS (☐ CHECK HERE IF NO MEDICATIONS)

List medications you are currently taking.

Have you taken or are you currently taking any bisphosphonates (Fosamax, Zometa, Actonel, Boniva, Didronel) for Osteoporosis, Multiple Myeloma, or Cancer Therapy? Please list the name and when you went on the medication.

Have you ever required antibiotics prior to dental appointments?

MEDICAL ALLERGIES (☐ CHECK HERE IF NO KNOWN DRUG ALLERGIES)

☐ Local anesthetic	☐ Antibiotics	☐ Aspirin	☐ Nitrous Oxide (laughing gas)
☐ Opiates Ex: Morphine, Fentanyl, Hydrocodone, Codeine	☐ Benzodiazepines Ex: Ativan, Valium, Xanax, Versed	☐ Topical anesthetic	☐ Other (please list):

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CONTACT INFORMATION

Conservator:	E-mail:	Phone:
Parent/Guardian:	E-mail:	Phone:
Primary Care Physician:	Fax:	Phone:
Pharmacy Name:	Address:	Phone:
Responsible party for scheduling appointment:	E-mail:	Phone:

DENTAL INSURANCE INFORMATION **

Policy Holder ('PH') Name:	'PH' Social Security Number:	'PH' Date of Birth:
Insurance Carrier:	Group Id:	Subscriber Id:

****Please provide front/back copies of any dental insurance card (if applicable).**

REFERRAL INFO

How did you find out about us?
☐ Google Search ☐ Yelp! ☐ Facebook ☐ Friend or Family ☐ Insurance Company ☐ Other: _____

Have you had any problems with dental treatment in the past?
○ Yes ○ No Comments:

Are you interested in dental treatment under sedation?
○ Yes ○ No Comments:

Have you had any problems with sedation or general anesthesia in the past?
○ Yes ○ No Comments:

Have you ever been hospitalized or undergone any surgeries?
○ Yes ○ No **Please describe:**

I understand that withholding any information about the patient's health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge.

Patient or parent/conservator signature _____ Date _____