

PATIENT INTAKE FORM

PROVIDER: _____ REFERRAL: _____

PHONE NUMBER: _____

CONTACT: _____

SECTION 1: TELEPHONE CALL

ASK

- | | |
|---|---|
| <input type="checkbox"/> Permission to ask | <input type="checkbox"/> Radiographs |
| <input type="checkbox"/> Client information | <input type="checkbox"/> Other records |
| <input type="checkbox"/> Reason for calling | <input type="checkbox"/> Special needs |
| <input type="checkbox"/> Nature of concern | <input type="checkbox"/> Referral/Invitation source |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
- INSURANCE**

TODAY'S DATE

DATE SCHEDULED

CLIENT INFORMATION

New Client

Existing Client

CLIENT FIRST NAME

CLIENT LAST NAME

ADDRESS

HOME TELEPHONE

BUSINESS TELEPHONE

CELL/PAGER TELEPHONE

FACSIMILE NUMBER

PATIENT'S CONCERNS

DOCTOR'S CONCERNS

RADIOGRAPHS

- Client bringing Request from Dr. Dr. sending None

CSF BWF PA OTHER

DOES GP WANT A PRE-CONSULT PHONE CALL FROM DR. BERLANGA? Yes No

DR. BERLANGA SPOKE WITH GP Yes No

CASE OPPORTUNITY Full Perio Iso Perio Implant Rx Sx Other _____

Do you have any evidence of periodontal disease? Yes No

Have you ever been diagnosed with a heart murmur or rheumatic fever? Yes No Mitral Valve Prolapse? Yes No

Have you had artificial joint or artery replacement? Yes No Are you pregnant? Yes No Latex allergy? Yes No

Have you ever taken the diet drug Fen-Phen, Redux or Pondimin? Yes No

SPECIAL NEEDS

- Disabled Medical alert

Pre-med _____ Pharmacy _____

Other needs _____

NP Letter _____

PND-1 _____

NP/DNS _____

PND-2 _____

NP/DNS-RD _____

IC _____

Mail 1 _____

IC-RD _____

Mail 2 _____