Auburn dental center

5603 Auburn St, Unit B, Bakersfield, CA 93306 · (661) 327-2189

# New Patient Intake Form

**Confidential Patient Health Information**

Today's date: ____ / ____ / _____

**Prefer to fill this out on your phone?** Go to **auburndentalgroup.com/newpatient** (English or Español). It takes about 10 minutes, and you can skip the clipboard at your visit.

Please print clearly. Items marked * are required. Everything on this form stays in your confidential record.

## 1 About You

*We'll use this to create the patient's chart and reach you about appointments.*

**Who are you filling this out for? *** ☐ Myself ☐ My child ☐ Someone I care for

| Patient's legal first name * | Legal last name * | Preferred name |
|---|---|---|
| | | |

| Date of birth (MM / DD / YYYY) * | Sex (as listed on insurance): ☐ Male ☐ Female ☐ Other * |
|---|---|
| | |

**Marital status (if this form is for you):** ☐ Single ☐ Married ☐ Domestic partner ☐ Prefer not to say

### Parent or guardian (only if filling this out for your child or someone you care for)

| Your full name | Relationship to patient |
|---|---|
| | |

### How we can reach you

| Mobile phone * | Email * |
|---|---|
| | |

**Best way to reach you: *** ☐ Text ☐ Call ☐ Email

| Street address * | City * | State * | ZIP * |
|---|---|---|---|
| | | | |

### Texts and emails from our office

Auburn Dental Center uses text messages and email as part of your care. We send appointment reminders, confirmations, forms, and billing notices this way.

**May we send you text messages? *** ☐ Yes, text me ☐ No texts

If you choose No, you won't get text reminders about upcoming appointments and won't be able to confirm by text. A member of our team will call you to confirm instead, and that call may not come at a convenient time for you, like while you're at work, driving, or busy with family. Without text reminders, it's also easier to forget an appointment and be charged the Missed-Appointment Fee. Most of our patients find texts much easier: one tap to confirm, whenever it suits you.

**May we send you emails? *** ☐ Yes, email me ☐ No emails

You can stop texts at any time by replying STOP or by telling our front desk. Message and data rates may apply.

Every appointment is time we set aside just for you, and often a time another patient was hoping to get. To be fair to everyone we care for, appointments missed or cancelled with less than 24 hours' notice have a $50 fee, which is added to your account.

We know you're new to our office, so we'll always do our best to remind you. Text reminders are the easiest way to keep your appointment or let us know early if your plans change.

### Emergency contact

| Name * | Relationship * | Phone * |
|---|---|---|
| | | |

### Who may we talk with about your care?

**May we discuss your appointments, treatment, or balance with anyone besides you?** * ☐ Yes ☐ No

| If Yes: their names and relationship to you |
|---|
| |

### How did you hear about us? *

☐ Website ☐ Google search ☐ Google ad ☐ Facebook ☐ Instagram

☐ Yelp ☐ Insurance provider ☐ Friend or family ☐ Existing patient ☐ Other

| Who referred you? (so we can thank them) | Other: tell us where |
|---|---|
| | |

## 2 Billing & Insurance

*We'll check your benefits before your visit so there are no surprises.*

### Who is responsible for this account?

**Responsible party:** * ☐ The patient ☐ Me, the person filling this out ☐ Someone else

If it's the patient or you, skip to Dental insurance. If someone else, fill in their information:

| Full name | Relationship to patient | Phone |
|---|---|---|
| | | |

| Employer (optional) | Mailing address ☐ Same as the patient's address ☐ Different (write below) |
|---|---|
| | |

| Street address | City | State | ZIP |
|---|---|---|---|
| | | | |

Are they currently a patient here? ☐ Yes ☐ No

### Dental insurance

**Do you have dental insurance?** ☐ Yes ☐ No ☐ Not sure

Not sure? Bring any card you have and we'll check for you. No insurance? We offer self-pay options and will go over them at your visit. We don't ask for Social Security numbers. Your member ID is all we need.

### Primary dental plan

| Insurance company | Group number |
|---|---|
| | |

| Member ID | Policy holder's employer |
|---|---|
| | |

Who is the policy holder? ☐ The patient ☐ Spouse ☐ Parent ☐ Other

| If not the patient: policy holder's name | Policy holder's date of birth (MM / DD / YYYY) |
|---|---|
| | |

### Second dental plan (if you have one)

| Insurance company | Group number |
|---|---|
| | |

| Member ID | Policy holder's employer |
|---|---|
| | |

Who is the policy holder? ☐ The patient ☐ Spouse ☐ Parent ☐ Other

| If not the patient: policy holder's name | Policy holder's date of birth (MM / DD / YYYY) |
|---|---|
| | |

### Third dental plan (if you have one)

| Insurance company | Group number |
|---|---|
| | |

| Member ID | Policy holder's employer |
|---|---|
| | |

Who is the policy holder? ☐ The patient ☐ Spouse ☐ Parent ☐ Other

| If not the patient: policy holder's name | Policy holder's date of birth (MM / DD / YYYY) |
|---|---|
| | |

Please bring your insurance card(s) and a photo ID to your visit. We'll copy them at check-in.

## 3 Health History

*Your overall health affects your dental care. Everything here stays in your confidential record.*

### Your doctor and pharmacy

| Physician's name (optional) | Preferred pharmacy (optional) | Pharmacy phone (optional) |
|---|---|---|
| | | |

Last doctor visit: ☐ Within 6 months ☐ 6–12 months ago ☐ 1–2 years ago ☐ More than 2 years ago ☐ Not sure

### A few quick questions

| | | |
|---|---|---|
| Are you currently being treated by a doctor for anything? * | ☐ Yes ☐ No | If Yes, what for? |
| Have you had any serious illnesses or operations? * | ☐ Yes ☐ No | If Yes, please describe |
| Have you had a blood transfusion? * | ☐ Yes ☐ No | If Yes, about when? |
| Has a doctor told you to take antibiotics before dental treatment? * | ☐ Yes ☐ No | |
| Have you ever taken a bone-strengthening medicine? (Such as Fosamax, Boniva, Actonel, Reclast, Prolia or Xgeva) * | ☐ Yes ☐ No | |
| Do you take a blood thinner? (Such as Eliquis, Xarelto, Warfarin or Plavix) * | ☐ Yes ☐ No | |
| Female or Other only: Are you pregnant? * | ☐ Yes ☐ No | ☐ Does not apply |
| Female or Other only: Are you nursing? * | ☐ Yes ☐ No | ☐ Does not apply |
| Female or Other only: Do you take birth control pills? * | ☐ Yes ☐ No | ☐ Does not apply |

### Medical conditions

For each category, tell us if you have now, or have ever had, any of the conditions listed. If Yes, check each one that applies.

| | | | |
|---|---|---|---|
| **Heart & circulation *** ☐ No ☐ Yes | ☐ High blood pressure<br>☐ Mitral valve prolapse<br>☐ Circulatory problems<br>☐ Swelling of feet or ankles | ☐ Heart problems<br>☐ Artificial heart valve<br>☐ Rheumatic fever<br>☐ Other: _____ | ☐ Heart murmur<br>☐ Pacemaker<br>☐ Stroke |
| **Lungs & breathing *** ☐ No ☐ Yes | ☐ Asthma<br>☐ Coughing up blood<br>☐ Sinus trouble | ☐ Respiratory disease<br>☐ Shortness of breath<br>☐ Other: _____ | ☐ Persistent cough<br>☐ Tuberculosis |
| **Blood *** ☐ No ☐ Yes | ☐ Anemia<br>☐ Other: _____ | ☐ Blood disease | ☐ Hemophilia or bleeding disorder |
| **Bones & joints *** ☐ No ☐ Yes | ☐ Artificial joints<br>☐ Jaw pain | ☐ Arthritis or rheumatism<br>☐ Other: _____ | ☐ Back problems |
| **Hormones & organs *** ☐ No ☐ Yes | ☐ Diabetes<br>☐ Ulcer | ☐ Thyroid problems<br>☐ Glaucoma | ☐ Kidney disease<br>☐ Other: _____ |

| | | | |
|---|---|---|---|
| **Cancer care** * ☐ No ☐ Yes | ☐ Cancer<br>☐ Cortisone (steroid) treatment | ☐ Chemotherapy<br>☐ Other: _____ | ☐ Radiation treatment |
| **Brain & nerves** * ☐ No ☐ Yes | ☐ Epilepsy or seizures<br>☐ Other: _____ | ☐ Fainting | ☐ Headaches |
| **Infections** * ☐ No ☐ Yes | ☐ Hepatitis<br>☐ Scarlet fever | ☐ HIV/AIDS<br>☐ Tonsillitis | ☐ Sexually transmitted infection<br>☐ Other: _____ |
| **Habits** * ☐ No ☐ Yes | ☐ Tobacco or vaping | ☐ Substance use disorder | ☐ Other: _____ |

**Any other health conditions, surgeries, or medical concerns not listed above?** * ☐ Yes ☐ No

If Yes, please describe, including any less common conditions

### Medications

**Do you take any medications?** * ☐ Yes ☐ No Include prescriptions, over-the-counter medicines, vitamins, and supplements.

| Medication | Dosage (if known) | What it's for |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Allergies

**Are you allergic to any medicines, latex, or other materials?** * ☐ Yes ☐ No

If Yes, check each one and tell us what happens (your reaction), like hives, rash, swelling, or trouble breathing.

| | |
|---|---|
| ☐ Aspirin | Reaction |
| ☐ Barbiturates | Reaction |
| ☐ Codeine | Reaction |
| ☐ Penicillin | Reaction |
| ☐ Sulfa drugs | Reaction |
| ☐ Latex | Reaction |
| ☐ Other antibiotic: _____ | Reaction |
| ☐ Something else: _____ | Reaction |

## 4 Dental History

*Help us understand what brings you in and how we can make your visit comfortable.*

### What brings you in? *

☐ Cleaning & checkup ☐ Tooth pain ☐ Broken tooth or filling
☐ Improve my smile ☐ Second opinion ☐ Something else: _____

**Last dental visit:** * ☐ Within 6 months ☐ 6–12 months ago ☐ 1–2 years ago ☐ More than 2 years ago ☐ Not sure

**Last dental X-rays:** ☐ Within 6 months ☐ 6–12 months ago ☐ 1–2 years ago ☐ More than 2 years ago ☐ Not sure

Previous dentist (office name and city, optional)

### Have you noticed any of these?

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food catching between teeth
☐ Grinding or clenching
☐ Loose teeth or broken fillings
☐ Past braces or aligners
☐ Past gum treatment
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Pain when biting
☐ Sores or growths in your mouth

### Your comfort

**How do you feel about dental visits?** * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 1 = very relaxed, 5 = very nervous

**Problems with dental numbing (local anesthetic)?** * ☐ No problems ☐ Yes, I had a problem ☐ Never had it

If you had a problem: what happened?

**How do you feel about the look of your teeth?** * ☐ I love it ☐ It's okay ☐ I'd like to improve it

### Anything you'd like the doctor to talk with you about?

☐ Invisalign
☐ Veneers
☐ Teeth whitening
☐ Headaches, migraines or TMD
☐ Teeth grinding (Bruxism)

## 5 Sleep & Snoring

*Sleep and dental health are connected. This quick screening helps your dentist spot problems early.*

| | |
|---|---|
| Do you snore, or has anyone told you that you snore? * | ☐ Yes ☐ No |
| Are you often tired during the day? * | ☐ Yes ☐ No |
| Has anyone told you that you stop breathing or wake up suddenly in your sleep? * | ☐ Yes ☐ No |
| Do you wake up with headaches? * | ☐ Yes ☐ No |
| Do you use a CPAP machine, or has a doctor told you to use one? * | ☐ Yes ☐ No |
| Have you ever had or been referred for a sleep study? * | ☐ Yes ☐ No |

### How likely are you to doze off?

Think about your usual routine lately. If you haven't done one of these recently, guess how it would affect you. This asks about falling asleep, not just feeling tired. Check one box per line.

| Situation | 0 Never | 1 Slight | 2 Moderate | 3 High |
|---|---|---|---|---|
| Sitting and reading * | ☐ | ☐ | ☐ | ☐ |
| Watching TV * | ☐ | ☐ | ☐ | ☐ |
| Sitting still in a public place, like a theater or meeting * | ☐ | ☐ | ☐ | ☐ |
| Riding as a passenger in a car for an hour without a break * | ☐ | ☐ | ☐ | ☐ |
| Lying down to rest in the afternoon * | ☐ | ☐ | ☐ | ☐ |
| Sitting and talking to someone * | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch without alcohol * | ☐ | ☐ | ☐ | ☐ |
| In a car, while stopped for a few minutes in traffic * | ☐ | ☐ | ☐ | ☐ |

## 6 Review & Sign

*Please read and check each item.*

### Agreements

☐ **Consent to treatment** *
I authorize the dentists of Auburn Dental Center to perform the exams, X-rays, and treatment needed for proper dental care.

☐ **Insurance release and payment** *
I authorize release of my (or my child's) dental information to my insurance to process claims, and I authorize my insurance to pay Auburn Dental Center directly.

☐ **Financial responsibility** *
I understand my insurance may pay less than the full fee, and I am responsible for any balance it doesn't cover.

☐ **Sharing records with another dentist** *
I authorize release of my (or my child's) dental information to another dentist involved in my care.

☐ **Missed appointments** *
I understand that appointments missed or cancelled with less than 24 hours' notice have a $50 fee, which is added to my account.

☐ **Privacy notice** *
I acknowledge that I was offered Auburn Dental Center's Notice of Privacy Practices. A copy is available at the front desk and on our website.

### Signature

☐ **I confirm this form is true and complete** *
I completed this form myself, or as the patient's parent or legal guardian. The information is true and complete to the best of my knowledge, and I have not left out any health condition, medication, or allergy that I know of. I understand my dentist relies on this information to provide safe care. I will not hold Auburn Dental Center or its staff responsible for errors or omissions in what I reported, and I will tell the dental team before treatment if my health or medications change.

| Signature * | Date * |
|---|---|
| | |

| Printed full legal name * | If signing for the patient: relationship (parent or legal guardian) |
|---|---|
| | |

## ★ Your Smile, Studio-Style (optional)

*Totally optional. Your care is the same either way.*

Every patient gets photos of their teeth for their dental chart, and those stay private. But when your results look amazing, we'd love to celebrate them with a professional studio portrait. That means our studio camera, professional lighting, and a tasteful, flattering shot you'll actually want to keep.

### Want to be in our Smile Spotlight? *

☐ No thanks, keep my photos private ☐ Smile Only (teeth, no face) ☐ Full Spotlight (face & smile)

☐ It's okay to use my first name ☐ I'm open to a short video (we'll always ask before filming)

Why patients say yes: a professional studio portrait, not a phone snapshot · you get copies of your before & after photos to keep and share · tasteful only, we never post unflattering shots · your last name and health details always stay private · change your mind anytime.

*If you chose Smile Only or Full Spotlight, please read and sign below. If you chose No, you can skip the rest of this page.*

### Photo Permission: Authorization to Use My Photos for Education & Marketing

By signing below, I give Auburn Dental Center permission to use my photos as follows:

- **What:** Photos, studio portraits, and video of the option I checked above (my smile only, or my face and smile), taken before, during, and after treatment. This includes my voice and anything I say on video, if I agreed to video. It also includes a short description of the treatment I received, and my first name only if I checked that box. My last name, birth date, and other health information will not be shared.
- **Who shares it:** Auburn Dental Center and its team.
- **Where it may appear:** The practice website and social media (such as Instagram, Facebook, TikTok, YouTube, and Google), as well as printed materials, ads, and patient education. Marketing partners who help create or post content may also see them.
- **Why:** To educate patients and promote Auburn Dental Center's services.
- **How long:** This permission ends 5 years after the date I sign below, unless I cancel it sooner.

**I understand that:**

- This is optional. Saying no will not affect my treatment, payment, insurance, or eligibility for care.
- I can cancel anytime by writing to 5603 Auburn St Unit B, Bakersfield, CA 93306 or info@auburndentalgroup.com. Canceling stops new uses but doesn't undo uses made before the office got my request. The office will remove my photos from its own website and social accounts within 30 days.
- Photos and videos may be edited for length, cropping, and lighting, but my treatment results will not be digitally altered.
- Once photos are posted publicly, other people may copy or share them. Those copies are no longer protected by privacy laws, and the office can't control them.
- I will not be paid, and Auburn Dental Center does not receive payment from anyone else for using my photos.
- I can request a copy of this signed form anytime.
- If the patient is under 18, a parent or legal guardian must sign and state their relationship.

| Signature for photo/video permission only | Date |
|---|---|
| Printed name | Relationship (if not the patient) |

**OFFICE USE ONLY**

☐ Entered in EHR ☐ Medical alerts entered ☐ Insurance card & ID copied ☐ Benefits verified

☐ Text/email preferences set ☐ Photo permission updated in EHR Staff initials: _____ Date: _____