New Patient Intake Form

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Date:

Name: _____ Date of Birth:
Y_____M_____D_____

What is the **main** reason for your visit today?

_____

Medications (including over-the-counter and those taken on as-needed basis):

_____

_____

Are you on any blood thinners?
aspirin No Yes
coumadin (warfarin) No Yes
Other:

_____

Allergies to Medications: No Yes

_____

Have you ever had a reaction to a local anesthetic (dental freezing)? No Yes
Do you need to take antibiotics before routine dental cleaning? No Yes
Have you ever had any skin cancer removed or biopsied? No Yes
Have you had any abnormal moles removed or biopsied? No Yes
Have any of your parents, siblings, or children had melanoma? No Yes

Do you or did you have:

Trouble fighting infections? No Yes
Difficulties with surgical infections, healing or scarring? No Yes
Bleeding disorder (excessive bleeding)? No Yes
Heart valve problems or artificial heart valve? No Yes
Pacemaker or implanted defibrillator (date)? No Yes
Hepatitis B or C? No Yes HIV/AIDS? No Yes
Excessive sun/UV exposure (e.g. tanning beds)? No Yes

Please list any other medical conditions you have:

_____

_____

_____

_____

Has there been any significant change in your health recently (weight loss, new symptoms)?

_____

List drug coverage that you have (e.g. No drug coverage, Alberta Blue Cross, Manulife, SunLife, Great West Life)