Milton DENTAL CLINIC
DR. Anjum and Associates

New Patient Intake Form

All information is confidential and protected under the Privacy Act and doctor–patient confidentiality.

Patient Information

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Given Name: _____ Last Name: _____
Preferred Name: _____
Marital Status: _____

Address: _____
Home Phone: (___) - ___-____
Cell Phone: (___) - ___-____
Email: _____

☐ Male ☐ Female ☐ Other: _____ Date of Birth: ___/___/____

Who may we thank for referring you to our office? _____

Preferred Appointment Times:
☐ Weekdays ☐ Weekends ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Other: _____

Emergency Contact

Name: _____; Relationship: _____
Phone: _____

Family Doctor: _____ Phone/Address: _____
Specialist (if applicable): _____ Phone/Address: _____

Insurance Information

Assignment of Benefits:
I hereby assign my benefits, payable from claims submitted electronically, to Dr. _____, and authorize direct payment to him/her. This authorization remains in effect until revoked in writing. Initials: _____

EDI Authorization:
I authorize release of information in claims submitted electronically to my dental benefits plan administrator and the CDS. I also authorize communication of coverage details to my dentist. This authorization remains in effect until revoked in writing. Initials: _____

Copayment and Financial Responsibility Policy

I acknowledge that I am responsible for all copayments, deductibles, and any fees for services not covered or only partially covered by my insurance plan. Such payments are due

at the time services are rendered unless alternative arrangements have been made in advance. Milton Dental Clinic offers pre-approved payment plans with monthly installments for eligible treatments, which must be arranged and documented prior to the commencement of care. Initials: _____

Primary Insurance
Subscriber: _____ Date of Birth: ___/___/___
Relationship: ☐ Self ☐ Spouse ☐ Other: _____
Subscriber ID: _____ Policy/Plan #: _____ Division/Sect #: _____

Secondary Insurance (if applicable)
Subscriber: _____ Date of Birth: ___/___/___
Relationship: ☐ Self ☐ Spouse ☐ Other: _____
Subscriber ID: _____ Policy/Plan #: _____ Division/Sect #: _____

Medical History

(All information is strictly confidential and used only for your dental care.)

1. Are you currently being treated for any medical condition, or have you been in the past year? ☐ Yes ☐ No
If yes, please explain: _____
2. Date of last medical check-up: _____
3. Any changes in your general health in the past year? ☐ Yes ☐ No
4. Medications/supplements (including non-prescription/herbal): _____
5. Allergies (including latex, medications, foods, etc.): _____
6. Any adverse reactions to medicines/injections? ☐ Yes ☐ No
If yes, details: _____
7. Do you have, or have you ever had (check all that apply):
☐ Asthma ☐ Heart or blood pressure problems ☐ Heart valve replacement/repair
☐ Congenital heart disease ☐ Heart transplant ☐ Prosthetic/artificial joint
☐ Conditions affecting immune system (HIV/AIDS, chemo, radiotherapy)
☐ Hepatitis, jaundice, or liver disease ☐ Bleeding disorder
☐ Hospitalizations/surgeries ☐ Diabetes ☐ Stroke ☐ Seizures/Epilepsy ☐ Tuberculosis
☐ Osteoporosis ☐ Kidney disease ☐ Cancer ☐ Arthritis ☐ Drug/alcohol dependency
☐ Thyroid disease ☐ Stomach ulcers ☐ Shortness of breath ☐ Heart murmur ☐ Other: _____
8. Any other conditions not listed? ☐ Yes ☐ No If yes, list: _____
9. Any family history of disease (e.g., diabetes, heart disease, cancer)? ☐ Yes ☐ No
If yes, list: _____
10. Do you smoke or use cannabis/tobacco products? ☐ Yes ☐ No
11. Are you nervous about dental treatment? ☐ Yes ☐ No
12. For women: Are you pregnant or breastfeeding? ☐ Yes ☐ No
If pregnant, due date: _____

Dental History

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other: _____
2. Current dental pain? ☐ Yes ☐ No If yes, describe: _____
3. Last dental visit & treatment: _____
4. How often do you brush? _____
5. Dental concerns (check all that apply):
   ☐ Bleeding gums ☐ Sensitivity (Hot ☐ Cold ☐ Sweet ☐ Biting ☐)
   ☐ Cosmetic concerns ☐ Bad breath/bad taste ☐ Snoring
   ☐ Clenching/grinding ☐ Clicking/popping jaw ☐ Anxiety during dental care
   ☐ Sores/growths in mouth ☐ History of oral cancer ☐ History of jaw surgery
   Other concerns: _____

Privacy & Office Policies

I acknowledge that I have been informed of this office's privacy policy and understand how my information will be used and disclosed. I understand that appointments are reserved exclusively for me, and 48 hours' notice is required for cancellations to avoid charges.

Patient Consent & Release

I certify that the above medical and dental history is accurate and complete to the best of my knowledge. I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I consent to consultation with my physician if required. I accept financial responsibility for all services provided to myself and/or my dependents.

Patient/Guardian Signature: _____ Date: ___/___/____
Reviewing Dentist: _____

Optional Photo/Media Release

I authorize Milton Dental Clinic to take and use photographs or videos of me/my child for the purposes of:
- Dental records and treatment planning
- Educational and professional presentations
- Clinic communications (including website, social media, and community outreach)

☐ Yes, I consent
☐ No, I do not consent

Signature: _____ Date: ___/___/____