New Patient Intake Form

Date:_____

Demographics

First Name _____

Last Name _____

Referred by _____

Address _____

City/State/Zip _____

Cell Phone _____ Alt Phone _____

Email _____

Dental History

Last Dental Visit _____

Previous Dentist _____

Recare Frequency _____ Last Hygiene Visit _____

Immediate Needs _____

☐ First Appt is Emergency Care Premedicate: Y or N

Dental Insurance

Insurance Company _____

Subscriber name: _____

Subscriber dob: _____ ID# _____

Insurance Company Phone # _____

☐ Eligible for FMX /PANO

☐ Eligible for COE