

## New Patient Dental Intake Form

### Patient Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  M  F Marital status:  Single  Married  Divorced  Separated  Partnership  Widowed

Employer or School: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse, partner or parent name: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you learn about our practice or whom may we thank for referring you? \_\_\_\_\_

Who is responsible for your account and payment? (if different from previous listing): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### Dental Insurance

Insurance company: \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Social Security # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ What is your annual maximum benefit? \_\_\_\_\_

Whose name is this insurance under? \_\_\_\_\_

Employer offering this insurance? \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Secondary Dental Insurance

Insurance company: \_\_\_\_\_ Phone # \_\_\_\_\_

Subscriber's Social Security # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ What is your annual maximum benefit? \_\_\_\_\_

Whose name is this insurance under? \_\_\_\_\_

Employer offering this insurance? \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Dental History

Reason for today's visit: \_\_\_\_\_

Date of last dental care visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Former dentist's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Check if you have any problem with the following:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Loose teeth or broken fillings
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Periodontal treatment
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Sensitivity to any of the following: cold, hot, sweets
<input type="checkbox"/> Food collection between certain teeth	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sores or growth in your mouth

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_