

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? _____