New Patient Intake Form

FOR OFFICE USE ONLY:

Date:

Patient Name:

Parent or Legal Guardian's Name:

Address:

Email:

Cell Phone: Home Phone: Work Phone:

Contact Preference: ☐ Cell ☐ Text ☐ Home Phone ☐ Work phone ☐ Email

How did you hear about our office? ☐ Referral ☐ Website ☐ Signage ☐ Coupon
☐ Other

Referral Source:

Are you experiencing any dental problems or have any dental concerns?
☐ Pain? ☐ Constant ☐ Occasional Where?
☐ Swelling? Where?

Are you under the care of a physician? ☐ Yes ☐ No

When was your last dental visit? Are x-rays available?

Name of previous dentist: Phone Number:

Address:

Do you have a dental benefit plan? ☐ Yes ☐ No

If Yes:

Member ID Number: Group Number:

Name of policy holder:

Policy holder's relationship to the patient:

Policy holder's birthdate:

Policy holder's employer:

Insurance company:

Address:

Phone number and/or insurance company website:

Scheduled appointment date:

Verification of Eligibility and Benefits by:

☐ Electronic ☐ Fax ☐ Verbal

Verification scanned, Saved or written in record date:

Maximum Benefits/Year: $

Deductible amount: $

Has deductible been met? ☐ Yes ☐ No

Does deductible apply to preventive services? ☐ Yes ☐ No

Determine frequency of preventive services: ☐ Twice per year ☐ Once every six 6 months

☐ Other

Date of last radiographs:

Prior tooth loss restrictions:

Any other restrictions or limitations:

Benefits remaining for benefit year:

Additional information:

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