Dental New Patient Intake Form

Personal Information

First Name

Last Name

Date of Birth

Gender

Address

City

State

Zip Code

Phone Number

Email Address

Insurance Information

Insurance Provider

Policy Number

Group Number

Subscriber Name

Subscriber Date of Birth

Medical History

Are you currently under a physician's care?

☐ Yes ☐ No

List any medical conditions

List current medications

List allergies

Do you smoke or use tobacco?

☐ Yes ☐ No

Dental History

Reason for today's visit

When was your last dental visit?

Do your gums bleed while brushing or flossing?

☐ Yes ☐ No

Are your teeth sensitive to hot or cold?

☐ Yes ☐ No

Other dental concerns

Emergency Contact

Name

Relationship

Phone Number

Signature

Date