Dental Patient Intake Form

First Name

Last Name

Date of Birth

Gender

Address

City

State

Zip

Phone

Email

Emergency Contact Name

Emergency Contact Phone

Relationship

Primary Physician

Medical History (Choose all that apply)

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Asthma
- [ ] None

Known Allergies

Current Medications

Reason for Dental Visit

Additional Notes