New Patient Dental Intake Form

Patient Information

Name: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____

Home phone: _____ Cell phone: _____ Email: _____

Social Security Number (required by some insurances): _____ - _____ - _____ Sex: ☐ M ☐ F

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnership ☐ Widowed

Employer or School: _____ Phone: _____

Person to contact in case of an emergency: _____ Phone: _____

Relationship to you: _____

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): _____

Dental Insurance

Subscriber Name: _____ Insurance company: _____

Subscriber or Member ID: _____ Group Number: _____

Employer offering this insurance: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance

Subscriber Name: _____ Insurance company: _____

Subscriber or Member ID: _____ Group Number: _____

Employer offering this insurance: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Consent and Acknowledgement

I certify that the above information is true and complete to the best of my knowledge. I authorize the dentist and or staff to release necessary information to my insurance company and understand I am financially responsible for all charges whether or not paid by insurance.

Patient/Guardian Signature: _____ Date: _____