NEW PATIENT INTAKE

PATIENT FIRST/LAST NAME: ____
ADDITIONAL FAMILY MEMBERS: _____

IS THIS AN EMERGENCY? **YES** **NO**

WHAT AREA OF MOUTH: **UR** **LR** **UL** **LL**
PAIN LEVEL: **1** **2** **3** **4** **5**
SWELLING? **YES** **NO** TEMP SENSITIVE? **YES** **NO**

PHONE NUMBER: **HOME** _____ **CELL** _____
EMAIL ADDRESS: _____
PREFERRED METHOD OF COMMUNICATION? **TEXT** **CALL** **EMAIL**

HOW DID YOU HEAR ABOUT OUR OFFICE? _____
REFERRAL? _____

WHEN WAS LAST VISIT TO A DENTAL OFFICE? _____
PREVIOUS OFFICE/DOCTOR NAME? _____
PHONE #: _____
DO YOU HAVE RECENT X-RAYS WE CAN REQUEST? **YES** **NO**

DO YOU HAVE ANY DENTAL INSURANCE? **YES** **NO**
INSURANCE COMPANY: _____
PHONE#:_____
SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____
SUBSCRIBER SS# OR MEMBER ID#: _____
GROUP #: _____
PATIENT DOB: _____
RELATIONSHIP TO SUBSCRIBER? **SPOUSE** **CHILD**