

# Dental New Patient Form

Patient Information			
First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status
Address		City	State Zip Code
Email		Preferred Phone Number	
Emergency Contact			
Full Name	Relationship	Contact Number	
Full Name	Relationship	Contact Number	
Health and Medical Information			
Primary Care Physician	Address	Contact Number	
Please list any medical conditions			
Please list any current medication			
Insurance Information (If Applicable)			
Insurance Carrier	Insurance Plan	Contact Number	
Policy Number	Group Number	Social Security Number	
Employment Status			
<input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____			
Occupation	Industry	Company Name	
Company Address		City	State Zip Code
All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.			
Parent or Guardian Name (If Applicable)		Relationship to Patient (If Applicable)	
Signature of Patient, Parent or Guardian		Date	