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		
Name	Relationship	Contact number
Name	Relationship	Contact number

Health 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			
☐ Employed	☐ Self-employed	☐ Unemployed	☐ 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 the patient's) health.

Parent or guardian's name (if applicable)	Relationship to patient (if applicable)
Signature of patient or guardian	Date