CHECKLIST FOR NEW PATIENTS

Date: ___________________________

Name: ____________________________ **Family Members**:

D.O.B. ____________________________

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Ph ________________________

Email _____________________

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Last Dental Visit ___________________ **Dentis**t _______________________________

Records Requested Y N **Ph #** _______________________________

Medical Conditions/Concerns ____

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Lost Fillings	Broken Teeth	Aches	Swelling
Loose Teeth	Sens Cold	Sens Hot	Pressure/On/Off
Pain Meds	Allergies	Mobility	How Long

Have you ever been told to take antibiotics prior to dental visits? Y N

Do you have an Insurance Policy with your employer? Y N

Employer ___________________________________Carrier__________________________

___________________________________ Plan # __________________________

___________________________________ ID # ___________________________

Our Payment Policy: We require payment in full at the time of your appointment. If you have insurance we will submit your claim for reimbursement directly to you.

What are your chief dental concerns? Function Aesthetics Other

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