# Dental New Patient Form

## PATIENT INFORMATION

First name: _____ Last name: _____

Preferred name: _____ Patient identifier (if known): _____

Gender: _____ Preferred pronouns: _____

Date of birth: _____ dd / mm / yyyy Marital status: _____

Address: _____ City: _____

State: _____ Zip code: _____

Email: _____ Preferred phone number: _____

## EMERGENCY CONTACT

1. Full name: _____ Relationship: _____

Contact number: _____ 2. 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

Select one:

◯ 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:** dd / mm / yyyy