New Patient Intake Form Dental

Welcome to Our Dental Practice

Please complete this form before your first appointment.

Personal Information

- **Full Name: _____**
- **Date of Birth: _____ / _____ / _____**
- **Address: _____**
  City: _____ State: _____ ZIP: _____
- **Phone Number: _____**
- **Email Address: _____**

Insurance Information

- **Insurance Provider: _____**
- **Policy Number: _____**
- **Group Number: _____**

Dental History

1. **Reason for Visit: _____**
2. **Are you currently experiencing dental pain? [ ] Yes [ ] No**
3. **Do you have any of the following?**
   [ ] Sensitivity to hot/cold [ ] Bleeding gums [ ] Grinding teeth
   [ ] Other: _____

Oral Hygiene Routine

How often do you brush your teeth? [ ] Once a day [ ] Twice a day [ ] Rarely

Do you floss regularly? [ ] Yes [ ] No

Acknowledgment

I confirm that the above information is accurate and complete.

Signature: _____ Date: _____