Pronounced _____ Date _____

Name _____ ◯ Adult or ◯ Child Age ( ) DOB of PT _____

Home Phone _____ Cell Phone _____ Parent / Guardian of Child _____

Address _____ City _____ ZIP _____

Who may we thank for referring you? _____ See Doctor _____

Email _____ Previous Dentist Name _____ Phone # _____

Date/Last FMX/BWX _____ Request: ◯ Yes or ◯ No

Emergency Patient:

Locations of Symptoms _____ Sympotoms _____

Pain Medication: ◯ Yes or ◯ No Type: _____

All Patients:

Insurance ◯ Yes or ◯ No Dental Plan _____ ID# _____ Phone # _____

Policy Holder: _____ Employer _____ DOB _____

Appointment Date _____ Welcome Letter Sent: ◯ Yes or ◯ No To Ins Desk _____