New Patient Screening Form Date _____

Patient Name _____ DOB _____SS_____

Address _____City _____Zip _____

Home Phone _____Work Phone _____ Cell Phone _____

E-Mail Address _____

Who may we thank for your referral? _____

Type of appointment desired _____

Date of last dental visit _____ Dentist _____Phone #_____

Previous office called for X-rays? _____ Sending _____

Medical History

Heart Attack_____ Stroke _____ MVP_____ Heart Murmur _____Joint Replacements _____

Diabetes _____Pregnant _____ Allergies _____ Coumadin _____ Aspirin

Pre Med Needed _____Mobility issues (stairs) _____

Physician Name _____ Phone # _____

Clearance Needed for _____ Requested _____ Received _____

Payment: Insurance _____ Cash _____ Grp/ID # _____

If minor – name of responsible adult _____ SS# _____

Name of insured _____ DOB _____

SS# _____ Relationship to Pt _____ Employer _____

Insurance Co _____ Phone # _____

Pt informed of 48 hrs notice _____ May not be a cleaning _____ Copay due at appt _____

Taken by _____ Welcome letter sent on _____ Referral thank you sent _____

Appointment Date _____ Time _____

Insurance Information Sheet

Patient Name _____ Date _____

Guarantor _____SS#_____Birth Date _____

Employer_____

Insurance Company _____Fee Sch _____Phone#_____

Address_____Grp#_____#of plans_____

Effective Date_____Family Coverage _____Single_____

Annual Maximum_____Policy Years Runs – Calendar_____Other_____

Deductible_____Yearly_____Lifetime_____Family_____

Preventative_____Frequency – Ex _____Pro_____

X-Rays_____FMX or Pano _____BWX_____

Fluoride_____Frequency _____Age Limit _____

Sealants _____Teeth Covered_____Frequency _____ Age Limit_____

Fillings _____ Resins on Posterior_____

Extractions _____ Nightguard _____

Perio _____Freq Limit on 4910_____Debride_____

Root Canals _____

Crowns _____

Bridges _____Missing Tooth Clause _____

Dentures_____Replacement _____

Ortho _____Maximum _____Deductible_____Age Limit_____

Implant _____Waiting Period _____