

New Patient Dental Registration & Consent

Please complete this dental intake form to help us provide you with safe, effective care. All information is confidential.

Patient Information

Tell us about the patient.

Full Legal Name *

Preferred Name (if different)

Date of Birth (MM/DD/YYYY) *

Phone Number *

Email Address *

Home Address (Street, City, State, ZIP) *

Is the patient a minor (under 18)? *

Yes

No

Responsible Party (if patient is a minor)

If the patient is under 18, please complete this section.

Responsible Party Name

Relationship to Patient

Responsible Party Phone Number

Responsible Party Email

Dental Insurance Information

If you have dental insurance, please provide details.

Insurance Company Name

Subscriber Name

Member/Policy Number

Group Number (if applicable)

Insurance Phone Number

Dental Health History

Help us understand your dental background.

Are you currently experiencing dental pain or discomfort? *

Yes

No

If yes, please describe your dental pain or discomfort.

Have you had any serious dental injuries or surgeries? *

Yes

No

If yes, please describe your dental injury or surgery.

Do you have any of the following dental habits? (Select all that apply)

- Grinding or clenching teeth
- Chewing ice or hard objects
- Frequent snacking/sugary drinks
- Mouth breathing
- Nail biting
- None of the above
- Other

Medical Health History

Your health information helps us provide safe dental care.

Primary Care Physician Name

Physician Phone Number

Are you currently under a physician's care for any condition(s)? *

Yes

No

If yes, please describe the condition(s) and treatment(s).

Please list all current medications (or write 'None'). *

Please list any drug or latex allergies (or write 'None'). *

Medical Conditions Checklist

Check any that apply and provide details as needed.

Please check any medical conditions you have had or currently have:

Heart condition

High blood pressure

Diabetes

Asthma or lung problems

Blood disorders

Thyroid problems

Seizures/epilepsy

Cancer or tumors

Kidney or liver disease

Joint replacement

Immunosuppression

Anxiety/depression

Other

If you checked any conditions above, please provide details (type, date, treatment, etc.).

Surgical History

List any major surgeries and dates, or write 'None'.

Surgical History Details

Consent for Treatment

Please review and acknowledge each statement below.

I understand the proposed dental treatment and authorize the dental team to perform necessary procedures. *

I agree

I understand that I am responsible for payment of all services not covered by insurance. *

I agree

Financial Policy Acknowledgment

Please review and acknowledge our financial policy.

I have read and understand the financial policy. I agree to the terms outlined. *

I agree

HIPAA Privacy Acknowledgment

Please review and acknowledge our privacy practices.

I have received and reviewed the Notice of Privacy Practices (HIPAA). *

I agree

Signature

Please sign below to confirm the information provided is accurate and that you accept the terms above.