

## **New Patient Form**

Name (first and last)*			
Date of Birth *			
Address *			
City	State	ZIP	
Employer			
Occupation			
Home Phone	Cell Phone		
Work Phone			
	minor)		
Date of Birth			
Address			
Address Line 2			
	State		
Home Phone	Cell Phone		
Work Phone			
Primary Dental Insurance Compa	ny		
Address			
Address Line 2			
City	State	ZIP	

## Subscriber Employee Name

First	Last		
Subscriber Employer			
Date of Birth	Social Security Number		
Member #	Group #		
Phone			
Relationship to Subscriber			
Secondary Insurance Company			
Address			
Address Line 2			
City	State	ZIP	
Subscriber Employee Name			
First	Last		
Subscriber Employer			
Date of Birth	Social Security Number		
Member #	Group #		
Person to contact in Case of Emergency *			
First	Last		
Phone *			
Is another member of your family a patient of	of Main Street Dental? *		
☐ Yes			
□ No			
If yes, what is their name?			

## **General Questions:** How did you hear about Main Street Dental? How long since your last dental visit? \_\_\_\_\_ Why did you leave your previous dentist? \_\_\_\_\_ What is the primary reason for this dental visit? \_\_\_\_\_ Are you experiencing dental pain or sensitivity? ☐ Yes ■ No If yes, how long? \_\_\_\_\_ How do you feel about your teeth in general? Are you happy with the appearance of your teeth? How often do you have your teeth cleaned? \_\_\_\_\_\_ Have you had any unpleasant dental experiences in the past?