New Patient Intake Form

General Information	
First Name	Last Name
Nick Name	Date of Birth
Address 1	Address 2
City, State Zip	
Email Address	Home Phone #
Cell Phone #	Work Phone #

Insurance		
Guarantor	Guarantor DOB	Guarantor SS#
Insurance Carrier	Employer Group	
Group #	800 Number for Insurance Verification	

Medical History	
Any medical history that requires pre-medication? ☐ Yes ☐ No Notes:	Are you experiencing any pain or have an area of concern? ☐ Yes ☐ No Notes:
Date of last dental visit	
Other Notes:	

INSURANCE BREAKDOWN OF DENTAL BENEFITS

App. Schd on:________/______/________@________ **Verified By:** **DATE:**

Home/Cell # ___________________________________ **Ins. Rep. Name:**

Subscri. Name:____________________________ **Sub. dob:**________________ **SS# or Id:** ______________

Group#

Payor Id#

FeeSchedule -

Pt. Name:____________________________________ Pt. DOB : ______________

Pt. Name:____________________________________ Pt. DOB : ______________

Employer: **Ins. Name:** **Ins. Pho #**

SINGLE COVERAGE **FAMILY COVERAGE** **INSURED/SPOUSE COVERAGE** **INSURED/CHILDREN COVERAGE**

Prev : ___________% Ded. Applies __________ **Ins. Effective Date:**________________________

Basic:___________% Ded. Applies : _________ **Ins. Calendar yr:**__________________________

Major: __________% Ded. Applies : _________ **Waiting Periods on Major:** _________________

Replacement Clause: 5yr 8yr 10yr **Crowns Paid:** seat or prep **Missing Tooth Clause:** ______________

Minimum Age Limit on PVC:__________ **PVC(2750) does it DWG:**___________**code**

Maximum: **Benefits Used:** **Deductible:** / **Deduc. Met:**

PA's (0220):PREV or BASIC ________________ Freq. **** (0140): PREV or BASIC** ________________________ Freq. **

D0460 (Pulp Vitality Test):______________ ** COMBINED OR SEPARATE **

Exams: 2/12months 2/per yr 1/per yr 1/6months **Prophy:** 2/12months 2/per yr 1/6months

D9310(Consult):_______________

BWX: 1/6months 1/12months 1/per yr 2/per yr **FMX/Pano:** 1/36months 1/5yrs

Cancer(0431)________________ **Deduc. Applies on Fmx/Pano:** Yes or No

Fluoride: 1/6mths 1/per yr 2/per yr 1/12mths 2/12mths **Age Limit:**________

Sealants: PREV or BASIC **Age Limit:** **Freq :** **PERM MOLARS/BICUSPIDS**

Perio: % **Endo:** % **Oral Surg:** % MEDICAL or DENTAL

D3331:______________________ **Arestin (4381):**_____________________________

SRP (4341): BASIC MAJOR (FREQ):____ **2quads or 4quads**

PMTX (4910):___________________________________ **D7220/D7230:**________________________________

BU (2950)% BASIC or MAJOR ________________________________ **Same Day As Crown? YES or NO**

IV: D9243_____________________________________ **D7953(BoneGraft):**____________________

Implants (6010):___________________________________ **Nightguard (9940):** ____

Posterior Comp. DWG 2 amalgam: Yes or NO

Ortho Coverage: Y/N ______________% Age Limit: _________________ Pd: Monthly / Quarterly

Lifetime Max: __________________ Deduc. ____________ Initial Pymnt: $ _______________________

NOTES:

PATIENT HISTORY:

Last-FMX / PANO:

Last-EXAM / BW'S:

Last-SEALANTS:

Last-CLEANING/ What type?:

Ins. Billing Address: