## **New Patient Intake Form**

Gender:   Female   Family Status:   Married   DOB:   2025-06-04	Step 1: Patient Information						
Address 1: 2770 west 5th Address 2: 4C Zip: 11224  Step 2: Primary Dental Insurance  Name of Insured: Relationship: father  Insurance Company: Group Number:  Insurance Phone: DOB:  Step 3: Responsible Party  Name: Relationship: Address:  Step 4: Medical History  [N] Currently under physician care [N] Taking medication [Y] Known allergies  Conditions  [X] Heart Disease [X] Asthma [X] Seizures [X] Hepatitis [X] HIV/AIDS [X] Bleeding Disorder [X] Diabetes [X] Anemia [X] Kidney Disease [X] Cancer [X] High Blood Pressure  Step 5: Consents  Signature of Patient or Guardian:	First Name: Gender:	Female	Family Status:	Married	DOB:		
Name of Insured: Insurance Company: Insurance Phone:  Step 3: Responsible Party  Name: Phone: Address:  Step 4: Medical History  [N] Currently under physician care [N] Taking medication [Y] Known allergies  Conditions [X] Heart Disease [X] Hepatitis [X] HIV/AIDS [X] Bleeding Disorder [X] Cancer [X] High Blood Pressure  Step 5: Consents  Signature of Patient or Guardian:  Name: Steve Faggs	Mobile: Address 1:					11224	
Insurance Company: Insurance Phone:    DOB:	Step 2: Primary Dental Insurance						
Name: Relationship:  Phone: Address:  Step 4: Medical History  [N] Currently under physician care  [N] Taking medication  [Y] Known allergies  Conditions  [X] Heart Disease [X] Asthma [X] Seizures  [X] Hepatitis [X] HIV/AIDS [X] Bleeding Disorder  [X] Diabetes [X] Anemia [X] Kidney Disease  [X] Cancer [X] High Blood Pressure  Step 5: Consents  Signature of Patient or Guardian:  Name: Steve Faggs	Name of Insured: Insurance Company: Insurance Phone:			Group Numbe			
Phone: Address:  Step 4: Medical History  [N] Currently under physician care  [N] Taking medication  [Y] Known allergies  Conditions  [X] Heart Disease [X] Asthma [X] Seizures  [X] Hepatitis [X] HIV/AIDS [X] Bleeding Disorder  [X] Diabetes [X] Anemia [X] Kidney Disease  [X] Cancer [X] High Blood Pressure  Step 5: Consents  Signature of Patient or Guardian:		iisible Faity		D 1 11 11			
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[X] Hepatitis [X] HIV/AIDS [X] Bleeding Disorder [X] Diabetes [X] Anemia [X] Kidney Disease [X] Cancer [X] High Blood Pressure  Step 5: Consents  Signature of Patient or Guardian:  Name: Steve Faggs	[N] Taking medic [Y] Known allerg  Conditions	cation					
Signature of Patient or Guardian:  Name: Steve Faggs	<ul><li>[X] Heart Disease</li><li>[X] Hepatitis</li><li>[X] Diabetes</li><li>[X] Cancer</li></ul>		[X] HIV/AIDS [X] Anemia		[X] Bleeding Disorder		
Name: Steve Faggs	Step 5: Consents						
Date:							