

New Patient Intake Form

Step 1: Patient Information

First Name:	Steve	Last Name:	Faggs	MI:	t
Gender:	Female	Family Status:	Single	DOB:	2025-06-01
Mobile:	1111111111	Home Phone:	2224445678	Best Time:	
Address 1:	2770 west 5th	Address 2:	4C	Zip:	11224

Step 2: Primary Dental Insurance

Name of Insured:	Relationship:	relationship
Insurance Company:	Group Number:	
Insurance Phone:	DOB:	

Step 3: Responsible Party

Name:	Relationship:
Phone:	Address:

Step 4: Medical History

[N] Currently under physician care

[N] Taking medication

[N] Known allergies

Step 5: Consents

Signature of Patient or Guardian: _____

Name: Steve Faggs

Date: _____