

New Patient Intake Form

Step 1: Patient Information

First Name:	Daniel	Last Name:	Shifrin	MI:	
Gender:	Female	Family Status:	Child	DOB:	2025-06-04
Mobile:	1111111111	Home Phone:	2224445678	Best Time:	
Address 1:	2770 West 5th Street	Address 2:	4C	Zip:	11224

Step 2: Primary Dental Insurance

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

Step 3: Responsible Party

Name:	Relationship:
Phone:	Address:

Step 4: Medical History

☒ Currently under physician care

☒ Taking medication

☒ Known allergies

Conditions

<input checked="" type="checkbox"/> Heart Disease	<input checked="" type="checkbox"/> Asthma	<input checked="" type="checkbox"/> Seizures
<input checked="" type="checkbox"/> Hepatitis	<input checked="" type="checkbox"/> HIV/AIDS	<input checked="" type="checkbox"/> Bleeding Disorder
<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Anemia	<input checked="" type="checkbox"/> Kidney Disease
<input checked="" type="checkbox"/> Cancer	<input checked="" type="checkbox"/> High Blood Pressure	

Step 5: Consents

Signature of Patient or Guardian: _____

Name: Daniel Shifrin

Date: _____