

New Patient Information Form



Welcome to our practice!

Today's Date _____

First Name _____ Last Name _____

Birth Date _____ Age _____

Social Security # _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Current dental insurance information, if we will be helping file claims for you:

Subscriber's Name _____ Subscriber's SS# _____

Subscriber's Date of Birth _____

Employer _____

Insurance Carrier _____ Secondary Insurance? _____

Group # _____

Name of previous Dentist _____

Date of last visit _____ Previous Dentist's Phone: _____

Are you experiencing any dental problems at this time?

Pain/Lost Filling/Broken Tooth? yes no If yes, where? _____

Swelling/Tooth Movement/Bleeding? yes no If yes, describe _____

Sensitivity to cold/heat/pressure yes no If yes, describe _____

Allergies to medications? yes no If yes, indicate _____

Currently pre-medicate before dental appointments? yes no

Due to: Artificial Joints, Prosthetic Heart Valves, Breast Augmentation(circle one)

If yes, Pharmacy Location and Phone # _____

Whom may we thank for referring you to our office?

Walk/Drive By Ins.Website Search/Website Mailer Other _____

Thank you for your time; we look forward to seeing you soon!

Sincerely,

Lincoln Place Dentistry