



## NEW PATIENT INTAKE FORM

### Patient Information

FirstName: \_\_\_\_\_ Last

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Gender:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Email: \_\_\_\_\_

### Pharmacy Information

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Preferred Contact method \_\_\_ Phone \_\_\_ Text \_\_\_ Email

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Consent and Acknowledgment

- I acknowledge that I have reviewed the office's privacy policy and understand my rights regarding my personal health information.
- I consent to dental treatment and authorize the release of necessary health information for billing and treatment purposes.
- I understand that I am responsible for all charges not covered by my insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_



Parent/Guardian Signature (if applicable):

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