

**NEW PATIENT CALL FORM**

PATIENT NAME: \_\_\_\_\_  
GUARDIAN'S NAME (if patient is a child): \_\_\_\_\_

**WELCOME THE PATIENT • INTRODUCE YOURSELF • BUILD TRUST**

WHO REFERRED YOU? (compliment referring patient) \_\_\_\_\_  
REASON FOR CALL (NEED)? JUST MOVED? NEW INSURANCE? PREVIOUS BAD  
EXPERIENCE? DISCOMFORT? \_\_\_\_\_

NOTE ANYTHING LEARNED ABOUT NP: \_\_\_\_\_

HYGIENE OR DOCTOR? \_\_\_\_\_  
APPT. DATE/TIME (ideally within 1-2 weeks) \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ HOME: \_\_\_\_\_ CELL: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PREFERRED METHOD OF COMMUNICATION Email  Text  Cell  Landline Phone

HOURS TO CONTACT: \_\_\_\_\_

Any restrictions on hours of contact? Yes  No  Is the patient a teacher (unavailable during the day)? Works night shift (sleeps during the day)? Elderly patients may not use email, text or have a cell phone.

ALLERGIES (especially latex) : \_\_\_\_\_

PREMED (antibiotics prior to visit due to heart murmur, joint replacement, etc):

\_\_\_\_\_

RX: DO THEY HAVE OR NEED ONE: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_

DATE RX CALLED IN: \_\_\_\_\_

DATE OF LAST DENTAL VISIT: \_\_\_\_\_

X-RAYS TAKEN AT A PREVIOUS DENTAL OFFICE? Yes  No

IF YES: NAME OF DENTIST: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

IS IT OK TO CONTACT PRIOR DDS FOR RECORDS? \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE?

If yes, get the following information:

Name of the insured person: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Is the insurance through an employer or self-purchased? \_\_\_\_\_

If through an employer, name of employer: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Phone number: \_\_\_\_\_

ID or SSN: \_\_\_\_\_ Group number: \_\_\_\_\_