**New Patient Sheet**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Pronunciation: \_\_\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell / Home / Work D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral (Chart ID): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gen DDS (if different from referral): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

App. Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Short Notice List: Yes/No Req. with Dr. Yu / Dr. L. / First Avail.

Who booked appointment? Self / Parent / Spouse / Dr. Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would your referring dentist like Dr. Yu or Dr. Litizzette to evaluate?

 **Per the Patient** **Per the Referral**

**Pre-Med**

Does your physician require you to take ABX prior to getting your teeth cleaned? Yes / No

If yes…Circle one: Mitral valve prolapse / Heat murmur / Joint replacements / Heart condition

If yes…Make sure to have your physician or gen DDS call in ABX to take 1 hour prior to appointment

**Insurance**

* Appointment is a 1 hour evaluation for $98 and we collect on D.O.S.
* Do you have dental insurance we can assist you with filing?
* We are out of network with all insurance companies but we will provide you the materials to file the claim as a courtesy

Insurance company name:

Insurance company phone #:

Group number (if available):

Policy Holder’s

 Name:

 Employer:

 SSN or Member #:

 DOB:

Policy Holder’s Address (linked to insurance):

**X-Rays and Information**

 X-rays: Pt will bring / PRN / Already Have / Requested X-rays & Referral Slip Date: \_\_\_\_\_\_\_\_\_\_\_