



NEW PATIENT SLIP

PHONE CALL:

Patient Name: _____ Patient DOB: _____

Responsible Party Name: _____ Relation: _____

Phone: _____ Email: _____

General Dentist: _____ How did you hear about our office: _____

Main Concerns: _____

Call received by: _____ Appt Scheduled: _____

PRIOR TO EXAM:

Intro/Confirmation Call Completed: _____

Sibling Accounts?: Forms Complete?: _____

Health History

Insurance Verified

Last Cleaning

EXAM FINDINGS:

Main Concerns: _____

Dentition: _____ Classification: _____

Other Findings: _____

Treatment Type: _____ Treatment Length: _____

Treatment Modality: _____

Notes: