BELLEVUE DENTAL OASIS
CARING FOR YOU AND YOUR SMILE

New Patient Form

Today's Date: _____ Appointment Date/Time: _____

Name: _____ Date of Birth: _____

Best Contact Phone #: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

How did you hear about our office? _____

What type of appointment did you need? *trouble with a tooth, if so, where is that tooth located?

_____

_____

_____

Do you know the date of your last dental visit?_____

Have you had any recent dental x-rays? Y □ N □

If so, previous DDS so that we may request those records: _____

Any additional family members we can schedule for you? Y □ N □

_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

Do you have any dental insurance? Y □ N □ Are you the policy holder? Y □ N □

Primary Subscriber Name: _____DOB: _____

Employer: _____

Insurance Company: _____ Phone #: _____

Member ID/ SS #: _____ Group #: _____

Claims Mailing Address: _____

Staff Initials: _____

□ Scanned
□ Referral source selected
□ Insurance verified

□ Eligible for FMX Y □ N □
□ Records release sent
□ Records release received
□ X-rays received and downloaded