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White Sands
HOLISTIC DENTISTRY

NEW PATIENT INTAKE FORM

INSTRUCTIONS:

Please fill out this form to the best of your ability. Upon completion, return by e-mail or fax. You will receive a confirmation e-mail welcoming you to our practice and confirming your appointment. If desired appointment date/time is not available, we will contact you to establish a new appointment.

****** PLEASE PRINT CLEARLY AND LEGIBLY ******

This form was completed on: ____/____/_____ (MM DD YYYY) Desired appointment: ____/____/_____ (MM DD YYYY) at ____:____ (HH MM)

Patient Name: _____ (FIRST) _____ (M.I.) _____ (LAST)

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Date of Birth: ____/____/_____ (MM DD YYYY)

e-mail: _____

Previous Dentist: _____ Phone #: _____

Last Known Dental Visit: ____/_____ (MM YYYY) Do you have any mercury/metal fillings? ☐ Yes ☐ No

Explain Dental Issue or Desired Dental Services: _____

_____

Referred By: ☐ Friend ☐ Relative ☐ Doctor Name of Referrer: _____

How Did You Find Us? ☐ Google ☐ Website ☐ Social Media ☐ IAOMT ☐ Walk-In ☐ Other

Additional Family Member: _____ Date of Birth: ____/____/_____ (MM DD YYYY)

Additional Family Member: _____ Date of Birth: ____/____/_____ (MM DD YYYY)

Vaccinated or boosted for COVID? ☐ Yes ☐ No If yes, last vacinnated or boosted on: ____/_____ (MM YYYY)

ACKNOWLEDGEMENTS

1.) Charge for adult new patient is $495.00. Services include X-rays, cone beam CT scan, examination/consultation. Dental hygiene/cleaning is NOT included and will require a separate subsequent appointment. We do NOT clean teeth with mercury/amalgam fillings.
2.) Charge for children up to age 14 is $240.00. Services include X-rays, examination/consultation and dental hygiene/cleaning. We do NOT clean teeth with mercury/amalgam fillings.
3.) We do NOT accept insurance. We DO accept cash, personal check, debit card, HSA card and credit card. A 3.5% fee will be applied for credit cards.
4.) We do NOT accept X-rays from other dental/medical facilities. We only take/use our own X-rays.
5.) If rescheduling or cancelling appointments is done within a 48 hour period prior to your appointment, a fee of $100.00 will be charged to your debit/credit card.
6.) Once we receive the NEW PATIENT **INTAKE** FORM, we will confirm your appointment(s) and send you a NEW PATIENT **PAPERWORK** FORM to fill out. The NEW PATIENT **PAPERWORK** FORM must be submitted to our office no later than the Friday prior to the appointment or the $100 fee will be charged. After receipt of this form, we will call to obtain your debit/credit card information to keep securely on file.

☐ I have read and understand all the acknowledgements listed above. Signature: _____