PATIENT INFORMATION

Pt. #_____

Date:_____ Sex: Male ❑ Female ❑

Patient's Name: Last_____ First_____ Middle _____

Address: Street_____ City_____ State_____ Zip_____

Home Phone:_____ Birthdate:_____ Age:_____ Social Security #:_____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____Name of family dentist:_____

RESPONSIBLE PARTY

Name: Last_____ First_____ Middle_____ Marital Status: _____

Social Security #:_____ Birthdate:_____ Relationship to Patient: _____

Email Address:_____

Employer:_____ Occupation:_____ No. Years Employed: _____

Residence: Street_____ City_____ State_____ Zip _____

Mailing Address: Street_____ City_____ State_____ Zip_____

How long at this address?_____ Home Phone:_____ Work Phone _____

Previous Address (if less than 3 years): Street_____ City_____ State_____ Zip_____

Spouse's Name: Last_____ First_____ Middle_____ Relationship to Patient: _____

Social Security #:_____ Birthdate:_____ Work Phone: _____

Email Address:_____

Employer:_____ Occupation:_____ No. Years Employed: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Relationship to Patient:_____

Complete Address: _____

Phone:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial): _____ _____ _____ _____ _____ _____