PATIENT INFORMATION (CONFIDENTIAL)

NAME	DATE		
ADDRESS	CITY	STATE	
CONTACT PHONE NUMBER:			
SS#BIRTHDATE			
EMPLOYER:	PHONE:		
CHECK APPROPRIATE BOX: □MINOR □SINGLE	= MARRIED DIVORCE D	WIDOWED SEPARATED	
Spouse NameEn	nployer		
PERSON TO CONTACT IN CASE OF AN EMERG	ENCY		
RELATIONSHIP TO YOU:	PHONE		
WHOM MAY WE THANK FOR REFERE	RING YOU?		
WOULD YOU LIKE TO RECEIVE EMAI APPOINTMENTS? Email Address_	L AND/OR TEXT MES		
Text msg #			
RESPONSIBLE PARTY (if not patient)			
Name:	Relationship to Patient:		
Address:	City	State	
Contact Phone Number:			
X SIGNATURE OF PATIENT OR PARENT/GUARDIA	AN IF MINOR	_	
+ + + + + + + + + + + + + +		+ + + + + +	
(For office staff use) DENTAL INSURANCE INFORMATION			
□scanned	_	□ NO DENTAL INSURANCE□ Appt Confirm	