Patient Information

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PERSONAL INFORMATION

Full Name _____ Today's Date _____
Mr. Mrs. Miss. Ms. Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

Whom may we thank for referring you to our practice? _____

Address _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

E-mail address _____

Preferred contact ❑E-mail ❑Home Phone ❑Work Phone ❑Cell Phone Best time to call _____

Employer _____ Occupation _____

Spouse / Partner _____ Cell Phone _____

Additional Emergency contact _____ Phone _____

Last dental visit _____ with Dr. _____

Physician _____ Phone _____

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _____

Have you been hospitalized in the last 3 years? ❑Yes ❑No _____

List medications you take - please include prescription and over-the-counter (Continue on other side if needed)

_____ _____ _____

_____ _____ _____

Why have you made this appointment _____
(Continue on other side if needed)

Payment preference: ❑Check ❑Cash ❑Credit Card

Financial Responsibility: ❑Self ❑Spouse ❑Parent ❑Other

_____