

Welcome To Our Office!



(Please Print)
PATIENT

Date _____

Name _____

Male Female Age _____ Birthdate _____ Home Phone _____

Address _____
Number and Street City Zip

Email _____

School _____ Grade _____

Responsible Party _____

Father's Name _____ Employed By _____

Position _____ Business Phone _____

_____ Cell Phone _____

Mother's Name _____ Employed By _____

Position _____ Business Phone _____

_____ Cell Phone _____

Children (Name & Age) _____

Employed By _____

Position _____ Business Phone _____

_____ Cell Phone _____

Spouse's Name _____

Employed By _____

Position _____ Business Phone _____

_____ Cell Phone _____

What would you like to see changed about your / your child's teeth? _____

Is there any significant medical or dental history that we should be aware of?

Medical: _____

Dental: _____

Allergies? _____ Allergic to Latex? Yes / No

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

Friends or Relatives treated here: _____

Patient's Dentist: _____

City

Child

Adult