Patient Information

Patient: Submitted: 11/7/2024

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws.

PATIENT INFORMATION

Patient Name:
Date of Birth:
Gender:
Social Security Number:
Primary Phone Number:
Email Address:
Address:
Address Line 2 (Optional):
City:
State:
Zip:

EMERGENCY CONTACT INFORMATION

1. Full Name:
Phone Number:
2. Full Name:
Phone Number:

REFERRAL SOURCE:

How did you hear about our office?
If applicable, provide the name of who we can thank:

PHARMACY INFORMATION

Do you have a preferred pharmacy that you would like us to keep on file?
Yes [ ] No [ ]
Pharmacy Name

SIGNATURE

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.