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DENTAL EXTRACTIONS * JAW SURGERIES * DENTAL IMPLANTS

PATIENT GET ACQUAINTED FORM

Patient's first Name: _____ Last Name:_____

Patient's Preferred Name: _____ Age:_____ Sex:_____ Date:_____

Date of Birth:_____ SSN# _____ _ DL# _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Spouse's Name:_____

Have you been a patient here before? ☐ Yes ☐ No If yes, what year?_____

Resident Address:_____ City: _____ State: _____ Zip:_____

Mailing Address:_____ City: _____ State: _____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Employer: _____

Employer's Address _____ City: _____ State: _____ Zip:_____

Emergency Contact: _____ Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Nearest Relative: _____ __Relationship to patient: _____

Address:_____ City: _____ State: _____ Zip:_____

Who referred your to our office? _____City: _____

Name of Dentist?_____ City: _____

Name of Physician: _____City: _____

Primary person responsible for payment, if other than patient

First Name:_____ Last Name: _____

Relationship to patient: ☐ Spouse ☐ Child ☐ Parent Other: _____

(Please specify if not blood related, e.g. step, half, divorced)

Date of Birth:_____ SSN# _____ _ DL# _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Employer: _____

Employer's Address _____ City: _____ State: _____ Zip:_____

Home Address:_____ City: _____ State: _____ Zip:_____

Is the above address where billing statements or refunds should be sent to? Yes No If not please add:

Address_____ City: _____ State: _____ Zip:_____

_____ _____

Signature of Patient Signature of responsible party