



Welcome New Patient

Date: _____

Patient's name: _____ DOB: _____ Age: _____

Pt ID: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

SS (If over 18): _____

Who is your general dentist?: _____ Last visit?: _____

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

Other family members treated here?: _____

If still in school, where? _____ Grade?: _____

Favorite sports/hobbies?: _____

RESPONSIBLE PARTY INFORMATION
(All PATIENTS UNDER 18 YEARS OLD)

Self (Same as above)

Responsible Party Name: _____ Relationship to Patient: _____

Marital Status: _____

DOB: _____ Social Security #: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Position: _____ Work Phone: _____

Parent/Guardian #2 Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Employer: _____ Email: _____

Is it ok to discuss financials with this parent or guardian #2? Yes No (Please circle)

EMERGENCY INFORMATION

Nearest Relative Name: _____ Relation: _____

Home Number: _____ Cell: _____

I understand that, where appropriate, credit bureau reports may be obtained.

X Signature (Parent's signature if minor): _____ Date: _____