## Patient Information

Name (First, MI, Last):_____

Circle all that apply

Married Single Minor Male Female

Address: _____ City, State, Zip_____

Date of Birth: _____

Social Security Number: _____

Home Phone: _____ Cell:_____ Work:_____

Email: _____

Place Of Employment: _____

Please Name the person responsible for this account and your relationship, if other than

yourself: _____

Emergency Contact: _____ Phone: _____

Has any member in your family been treated in our office? Yes No

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

Are you currently or have you in the past been treated for a Heart Murmur, Joint replacement, or any other medical condition that requires antibiotic pre-medication prior to dental treatment?

**Yes No**

If yes, please explain: _____

## Payment

Please indicate the method of payment for today and future appointments:

___Payment in full at each appointment

We Accept: Cash, Check, Visa, MasterCard, American Express, and Discover

___Payment utilizing Care Credit financing (If eligible)