PATIENT INFORMATION

Patient Name: _____ **Date:** _____
Last First

Social Security #: _____ - _____ - _____ **Date of Birth:** _____

Phone: (Cellular): _____ **(Home):** _____

Email Address: _____

Mailing Address: _____
Street Apt #

_____
City State Zip code

Appointment times are reserved just for you. If you are unable to keep your appointment, we ask for at least **48 business hours** in advance notice. We do have a broken appointment fee of **$65 per hour** that applies for any appointment not cancelled/rescheduled within this time.

Have you ever had any complications following dental treatment? _____ **YES** _____ **NO**
If yes, please explain:

_____
_____
_____

Is there any dental concern that you have? _____ **YES** _____ **NO**
If yes, please explain:

_____
_____
_____

Pharmacy name: _____

Pharmacy number: _____

Emergency contact: _____
Name Phone Number

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or information I will inform the doctors and staff at the next appointment without fail.

Signature: _____ **Date:** _____