

Please take a few minutes to fill out the following forms as completely as you can. If you have any questions we'll be glad to assist you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient Name: _____ Date: _____
 Last *First* *MI*
 Male Female Married Single Child Other: _____
Social Security #: _____ Date of Birth: _____
Phone (Home): _____ Phone (Cell): _____
E-mail: _____
Address: Street: _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____

EMPLOYMENT INFORMATION

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: Street: _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
 Last *First* *MI*
 Male Female Married Single Child Other: _____
Social Security #: _____ Date of Birth: _____
Phone (Home): _____ Phone (Cell): _____
Address: Street: _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____ Phone: _____

REFERRAL INFORMATION

How did you learn about our practice? TV Show TV Commercial Channel? _____
 Mini Implant Website Dr. Rodriguez Website Other Website? _____
 Another patient, friend Another patient, relative Another doctor Other: _____
Name of person or office referring you to our practice: _____