Patient Information

Name____Preferred Name____________________________

Parent/Guardian (if minor child)____

Address____Unit________________________

City________________________State________________________ZIP________________________

Home Phone___________________Work Phone___________________Cell Phone___________________

Email____Date of Birth (mm/dd/yy)___________________

Who may we thank for referring you?____

Why are you here today?____

Emergency Contact

Name____

Home Phone___________________Work Phone___________________Cell Phone___________________

Relationship to Patient: Parent / Guardian / Spouse / Other:_______________________________

Y N Are you satisfied with the appearance of your teeth?

Y N Are you interested in Sleep Dentistry?

Y N Would you like a whiter smile?

Y N Would you like straighter teeth?