**Patient Information Sheet**

Full Name ________________________________ Age _______ Birthdate __________

Mailing Address __________________________________________________________

Home Phone _________________________ OK to contact? YES No
Work Phone _________________________ OK to contact? YES No
Cell Phone __________________________ OK to contact? YES No
Email ______________________________ OK to contact? YES No

Occupation _____________________ Employed By __________________________

Social Security Number (for insurance form) _______________________________

Dental Insurance? _____________________________________________________

**Please list family members under our care:**

_______________________________ _______________________________

_______________________________ _______________________________

How did you hear about us? _____________________________________________

Whom may we thank for referring you? ___________________________________

**(Fill out only if someone else is responsible for your account):**

Person Responsible for Account ___________________________________________

Address _______________________________________________________________

Occupation _____________________ Employed By __________________________

Home phone ____________________ Work Phone ___________________________

Email _________________________________________________________________