

Lalor Creekside Dental

Patient Information

Date_____

First Name:_____ Middle_____ Last Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Date of Birth:_____ Social Security #:_____

Sex:___M___F Marital Status: ___Married ___Single ___Widowed

E-mail:_____

Emergency Contact: _____ Relationship to patient_____

Phone Number:_____

How did you hear about our office? _____

If referred, whom may we thank? _____

Responsible Party (if someone other than patient)

First Name:_____ Last Name:_____

Relationship to Patient:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Date of Birth:_____ Social Security #:_____

Employment Information

Employment Status: ___Full-time ___Part-time ___Retired ___Unemployed

Occupation:_____

Employer:_____

Student Status: ___Full-time ___Part-time

Signature of Patient

Parent or Guardian

Date

(Please turn over)

