

Welcome To Our Practice

We would like to welcome you to our practice. In an effort to know you better,
Please complete the following important information.

Date _____, 20____

Who can we thank for referring you to our office? _____

Patient's Name _____ Male _____ Female _____
Last First Middle Nickname

Patient's Address _____ Birth Date _____
Street City State Zip

Mailing Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____ SS# _____

Employer _____ Address _____ Occupation _____

Spouse's Name _____ Marital Status _____
Last First Middle

Spouse's Employer _____ Address _____ Work Phone _____

Responsible Party Information

Name _____ Relation to Patient _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birth Date _____ SS# _____

Employer _____ Address _____ Occupation _____ # of Yrs _____

Emergency Notification Information

In case of emergency, who should be notified?

Name _____ Phone _____ Relationship _____

Address _____ City _____ State _____ Zip _____

To the best of my knowledge, all of the proceeding information is true and correct. I will inform your office of any changes to the information above. I understand that, where appropriate, a credit bureau report may be obtained. I also acknowledge receiving a copy of the Dental Associates of South OKC Notice of Privacy Practices.

Signature of Patient or Guardian

Date