



PATIENT INFORMATION

We are looking forward to seeing you at your upcoming appointment. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PATIENT NAME

Name: _____
Last First MI Preferred

Address _____ City _____ State _____ Zip Code _____

Birthdate: _____ SS #: _____ Gender: M F Marital Status
Work Phone: _____ Wireless Phone: _____ Single
Email: _____ Divorced
Widowed

How did you hear about us?

(If someone referred you here, please enter their name so we can thank them.)

Responsible Party

Name: _____ Relationship _____
Last First

Address _____ City _____ State _____ Zip Code _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

Who to Contact:

I hereby give permission to Shorewood Family Dental Care to disclose any information related to my dental treatment with the following family member:

First Name Last Name

Phone Number Relationship

I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my dental treatment.

If the above method of Communication is by phone, check the appropriate box:

- OK to leave message with detailed information
- Leave a message with a call-back number

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for dental information from persons not listed above will require my specific authorization prior to the disclosure of any dental treatment.

Signature: _____