Anita W. Elliott, D.D.S., P.C.

Patient Information—

PATIENT NAME _____

☐Female ☐Male ☐Married ☐Single ☐Minor

Street Address _____

City _____ State _____ Zip Code_____

Home Tel _____ - _____ - _____ Work Tel _____ - _____ - _____

e-mail address _____

I.D/S.S.# _____ - ____ - _____ Birthdate _____ / _____ / _____

INSURANCE PROGRAM_____EMPLOYER_____

PERSON RESPONSIBLE FOR ACCOUNT_____

Has any member of your family been seen in our offices? ☐Yes ☐No

Whom may we thank for referring you to our office? _____

Name of person to contact outside of immediate family/household in case of emergency:

_____ Tel: _____

Address: _____

	FATHER (OR HUSBAND)	MOTHER (OR WIFE)
Name	_____	_____
Address	_____	_____
Home Tel	(_____) _____ - _____	(_____) _____ - _____
Work Tel	(_____) _____ - _____	(_____) _____ - _____
Birthdate	_____ / _____ / _____	_____ / _____ / _____
I.D/S.S.#	_____ - _____ - _____	_____ - _____ - _____
Employer	_____	_____
Insurance	_____	_____
Group #	_____	_____

I authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for delivery of proper dental care. I will be given an opportunity to ask questions and have all questions answered fully. The information on this page and all proceeding pages, including the medical history, are correct to the best of my knowledge.

Responsible Party Signature _____Date _____

☐Adult Patient ☐Father (or Husband) ☐Mother (or Wife) ☐Guardian