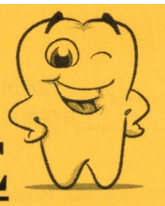
# WELCOME



## Patient Information:

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be glad to help you.

(Please Print) DATE:_____

NAME:_____ BIRTHDAY:_____

(FIRST) (MI) (LAST)

ADDRESS:_____ APT#:_____

CITY:_____ STATE:_____ ZIP:_____

SEX: Female Male

(CIRCLE ONE)

EMAIL:_____

HOME:(____)_____ CELL:(____)_____

DO YOU PREFER: TEXT CALL CELL CALL HOME ARE YOU: MARRIED SINGLE MINOR

(CIRCLE ONE) (CIRCLE ONE)

PERSON TO CONTACT IN CASE OF EMERGENCY:_____

RELATION TO PATIENT:_____ PHONE:(____)_____

## Demographics:

RACE: (CIRCLE ONE)

NATIVE AMERICAN ASIAN AFRICAN AMERICAN

CAUCASIAN PACIFIC ISLANDER ALASKAN NATIVE

NOT DISCLOSED OTHER:_____ (PLEASE SPECIFY)

ETHNICITY:(CIRCLE ONE)

HISPANIC OR LATINO NOT HISPANIC OR LATINO UNKNOWN

PREFERRED LANGUAGE:(CIRCLE ONE)

ENGLISH SPANISH CHINESE FRENCH ITALIAN RUSSIAN

PORTUGUESE OTHER:_____ (PLEASE SPECIFY)

CONFIDENTIAL