PATIENT INFORMATION (CONFIDENTIAL) **DATE:**

Name: _____ Date of Birth : _____
First MI Last

Address: _____ City:_____ State: _____ Zip:_____

Home Phone: _____ Cell: _____ E-Mail Address: _____

Employer:_____ Work Phone:_____

Check Appropriate Box: ☐Minor ☐Single ☐Married

Are you a State Fair Community College student? ☐Yes ☐No

Spouse or Parent's/Guardian's Name: _____

Previous Dentist: _____ Date of Last Dental Exam:_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone:_____

RESPONSIBLE PARTY

Name of Person Responsible for Charges **IF** different from Patient: _____

Relationship to Patient: _____

Address **IF** different from Patient: _____

HEALTH HISTORY REVIEW/MODIFICATIONS

List any medications you are currently taking including vitamins and herbs: **OR** Write **See Attached List**

_____

_____

_____

_____

_____

_____

_____

Signature of Patient or Parent/Guardian if Minor

State Fair Community College