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