**PATIENT INFORMATION FORM**

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| --- | --- | --- | --- | --- | --- | --- |
| Patient Last Name:Click here to enter text. | | | Patient First Name: Click here to enter text. | | | Middle Initial: Click here to enter text. |
| Patient Street Address: | Click here to enter text. | | | | | Apt: Click here to enter text. |
| City: Click here to enter text. | | State: Click here to enter text. | | | Zip Code: Click here to enter text. | |
| Date of Birth: Click here to enter a date. | | | | Telephone Number: Click here to enter text. | | |
| Email Address: Click here to enter text. | | | | | | |
| Has any member of your family been treated by our office? Click here to enter text. | | | | | | |
| Whom may we thank for referring you to our practice? Click here to enter text. | | | | | | |

**FAMILY INFORMATION**

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| --- | --- | --- | --- | --- | --- | --- |
| Last Name:Click here to enter text. | | | First Name: Click here to enter text. | | | Middle Initial: Click here to enter text. |
| Patient Street Address: | Click here to enter text. | | | | | Apt: Click here to enter text. |
| City: Click here to enter text. | | State: Click here to enter text. | | | Zip Code: Click here to enter text. | |
| Date of Birth: Click here to enter a date. | | | | Telephone Number: Click here to enter text. | | |
| Email Address: Click here to enter text. | | | | | | |
| Relationship to Patient: Click here to enter text. | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last Name:Click here to enter text. | | | First Name: Click here to enter text. | | | Middle Initial: Click here to enter text. |
| Patient Street Address: | Click here to enter text. | | | | | Apt: Click here to enter text. |
| City: Click here to enter text. | | State: Click here to enter text. | | | Zip Code: Click here to enter text. | |
| Date of Birth: Click here to enter a date. | | | | Telephone Number: Click here to enter text. | | |
| Email Address: Click here to enter text. | | | | | | |
| Relationship to Patient: Click here to enter text. | | | | | | |

**Emergency Contact Information**

|  |  |
| --- | --- |
| Name: | Telephone Number: |

Authorization: I hereby authorize Bronson Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as maybe necessary for proper dental care. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical history are correct to the best of my knowledge.

|  |  |
| --- | --- |
| Signature: Click here to enter text. | Date: Click here to enter a date. |