**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. |

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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. |

**Emergency Contact Information**

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| --- | --- |
| 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.

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