CLEAR CREEK DENTISTRY

New Patient Information

Date _____

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ SS#. _____

Email Address: _____ Best time to Call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext.) _____ (Mobile) _____ (Fax) _____ (Other)

**Please circle preferred contact number.*

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Employer

_____

Occupation

_____

Whom may we thank for referring you to our practice.

_____

Previous Dentist - Name and Phone Number

_____

May we contact your previous Dentist for dental records?

☐ Yes ☐ No