PATIENT INFORMATION

Clemson Family Dentistry

Today's Date: _____

Patient Name:

_____

Preferred Name:

_____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____

Relationship: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____

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

Mailing Address (if different than above): _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Email Address: _____

Occupation: _____ Employer/School: _____

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

Martial Status: ☐ Single ☐ Married Spouse Name: _____

Are other family members patient in our office? ☐ Yes ☐ No

If yes, please list: _____

Person responsible for payment (if not patient)? _____ Relation to Patient: _____

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

How will this account be paid? ☐ Cash ☐ Check ☐ Mastercard/Visa

How did you hear about our office? Who recommended our office? _____

Previous Dentist: _____ City: _____

I have answered all questions truthfully. I, or the above named person, guarantee payment of all fees incurred by this patient, I give permission for dentists, dental assistants, and dental hygienists to perform treatment for which they are qualified and allowed by law.

Signature of Patient/Legal Guardian: **Date:**

_____ _____