



# Gilford Dental

## PATIENT INFORMATION FORM

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

### PATIENT INFORMATION

Name: \_\_\_\_\_ Pronoun \_\_\_\_\_  
Last First

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_ Gender:  M  F  Other Married:  Y  N

Preferred Pharmacy: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Wireless Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Contact Method:  HmPhone  WkPhone  WirelessPh  Email  TextMessage

Preferred Contact Method for Confirmations:  HmPhone  WkPhone  WirelessPh  Email  TextMessage

Student status if dependent over 19 (for  Nonstudent  Fulltime  Parttime

How did you hear about us?

\_\_\_\_\_  
(If someone referred you here, please enter their name so we can thank them.)

### MAILING/PHYSICAL ADDRESS

Check box if same for entire family:

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Relationship to you/patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_