Patient Information

Welcome to Art of Dentistry! We will always do our best to earn the trust that you have placed in us. Please fill out these forms.

Personal Information

Patient's Full Name: _____ Date of Birth: _____

Preferred name: _____ Social Security #: _____

☐ Female ☐ Male Marital Status: _____ Driver's Lic #: _____

Complete Address: _____

E-mail: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext_____

Parent/Guardian

Is patient a minor *(under 18)*? ☐ Yes ☐ No If Yes, fill out the following information for the parent or guardian:

Full Name: _____ Relationship to Patient: _____ Phone #: _____

Emergency Contact

Complete the following information about the patient's emergency contact:

Full Name: _____ Relationship to Patient: _____ Phone #: _____

Communication Preferences

Detail below the communication preferences for the patient (or guardian if patient is a minor):

Please mark your preferred method/s of communication:

☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

We may send appointment confirmations and reminders via automated text message or email:

Can you receive text messages? ☐ Yes ☐ No

Can you receive emails? ☐ Yes ☐ No

Can we leave a voicemail on your . . .

home phone? ☐ Yes ☐ No

cell phone? ☐ Yes ☐ No

Media Release

As a patient of Art of Dentistry, PLLC, I understand that my photographs and radiographic images will be used for inclusion in my dental records and if required by law enforcement.
In addition, I hereby consent that photographs, video pictures, and/or radiographic images can be taken of me and used by Art of Dentistry, PLLC.

For any purpose of illustration, teaching, publication in dental journals, or for any other dental purpose deemed appropriate. ☐ Yes ☐ No

Use on social media sites to to demonstrate final outcomes. ☐ Yes ☐ No

Publicity or ad campaigns. ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Print Name Relationship to Patient