

TODAT SDATE:		
_	DO YOU HAVE AN APPOINTMENT:	YES / NO

INITIAL VISIT

Office Use Only: Check in Time:

PATIENT NAME:	ENT NAME: DATE OF BIRTH:		BIRTH:	
PATIENT SOCIAL SECURITY NU	MBER:	RACE:	HISPANIC	: YES / NO
ADDRESS:				
MAILING ADDRESS:				
		OTHER PHONE #:		
CURRENT SCHOOL:				
		NAME OF DENTAL INSURANCE		
PHARMACY	ADDRESS	_PHONE#_		
PARENT/GUARDIAN NAME:		RELATIONSHIP TO PATIENT		
WHEN WAS PATIENT LAST SEEN BY A DENTIST:		REASO	N SEEN:	
WHAT TREATMENT WAS DONE	:			
DENTIST'S NAME:		WERE 2	K-RAYS TAKEN:	YES / NO
DENTIST'S LOCATION, PHONE #	:			
FULL NAMES OF ALL HOUSEHOLD MEMBERS		DATE OF BIRTH	RELATIONSHIP TO PATIENT	

Chart Number: ____