Miller Oral Surgery

PATIENT INFORMATION

Please complete both sides of form

Date_____

Last Name_____ First Name_____ M.I. _____

Mailing Address_____ Apt # _____

City_____ State_____ Zip Code:_____

Sex_____ Age_____ Date of Birth _____ Marital Status S / M / D / W

Employer_____ Social Security # _____

Home Phone_____ Work Phone_____ EXT_____ Cell Phone _____

Nearest Relative or Emergency Contact_____ Phone# _____

Accompanying Parent/Guardian/Power of Attorney

Name_____ Social Security # _____

Address _____

Employer _____

Home Phone #_____ Work Phone #_____

Date of Birth_____ Relationship to Patient _____

If we need to take an X-Ray, do we have your permission?_____ (please initial if giving consent)

continued on reverse side