Patrick Mitsos DMD
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Personal Information

Today's Date: _____

Patient's Name: _____

Preferred Name: _____

Gender: ☐ male ☐ female Age: _____

Date of Birth: _____/_____/_____

Status: ☐ minor ☐ single ☐ married

Social Security # (only if over 18):____-___-_____

Home Address: _____

_____

_____

Billing Address (if different): _____

_____

_____

Please check preferred phone number:

☐ Home #: (____) - ____ - _____

☐ Cell #: (____) - _____ - _____

☐ Work #: (____) - ____ - _____

Check this box if you'd prefer NOT to receive text messages: ☐

E-mail address: _____

Do you have dental insurance? ☐ Yes ☐ No if yes,

What insurance company: _____

Primary Insured's Name: _____

Primary Insured's Date of Birth: _____

Primary Insured's Employer: _____

Person Responsible for account: _____

Referred to us by: ☐ Insurance ☐ Internet

☐ Existing Patient: _____

Dental Information

Reason for Today's Visit: ☐ Exam/Cleaning

☐ Emergency ☐ Consultation

Are you in pain? ☐ Yes ☐ No

How long have you been in pain? _____

Have you ever been told by a physician that you required antibiotic premedication prior to dental appointments? ☐ Yes ☐ No

Approximate date of last dental visit: _____

Do you have any concerns about your teeth, gums or jaw? _____

_____

_____

Is there anything you would like to inform the doctor about past/future dental treatment? _____

_____

_____

In the Event of Emergency

Emergency contact name: _____

Relationship to patient: _____

Best contact phone #: _____

Medical Doctor Name: _____

_____

Medical Doctor Phone Number: _____