

Patient Registration

III. Social History

Patient's First Name _____ Middle _____ Last _____

Preferred Name _____ Age _____ Sex _____ Date of Birth _____ SS# _____

Hobbies _____

Child lives with: Both parents Mother Stepmother Father Stepfather Grandparent
 Other _____

Any Siblings who are patients? _____

Patient's Address _____ Home Phone # _____

City/State/Zip _____

Email for appointment contact _____

Father/Guardian's Full Name _____ SS# _____

Driver's License # _____ Father's date of birth _____

Address _____ Home # _____

Where Employed _____ Work # _____ Cell # _____

Occupation _____

Mother/Guardian's Full Name _____ SS# _____

Driver's License # _____ Mother's date of birth _____

Address _____ Home # _____

Where Employed _____ Work # _____ Cell # _____

Occupation _____

Whom may we thank for referring you to our office? _____
(Please enter full name of doctor, school, or person)

Name of closest relative or friend not residing with patient who we may contact in case parents cannot be reached _____ Home # _____ Cell # _____

Reason for bringing child to the dentist _____

As Parent or Guardian of the above named child, I give my consent to needed dental services and use of proper and acceptable methods to complete dental exam. I authorize release of any and all information: radiographs, photographs, and models. I also allow for photographs to be used at the discretion of Palmetto Smiles. I also accept responsibility of payment of the services provided for my child. For the safety of your child, please remain in the office during your child's visit in case you are needed by our staff.

Parent or Guardian

Date