



Jorge Oaxaca DDS, Inc. and Howard Ong DDS, FAGD, Inc.

Restorative, Cosmetic and Implant Dentistry

WELCOME

About the patient:

Today's Date: ___/___/___

Patient Name: (Last)_____ (First)_____ (MI)_____ M/F

Birthdate: ___/___/___ Age: ___ SS#: _____

Mailing Address: _____

City State Zip

Home phone #: (____)_____ Work phone#: (____)_____ Cell# (____)_____

E-mail address:_____ Referred by: _____

Status: Child__ Single __ Married __ Divorced __ Separated __ Widowed __

Employer Info:

Employer: _____ How long? _____

Employer's Address: _____ City _____ ST _____ Zip _____

Occupation: _____

Account Info:

Person ultimately responsible for account (if different from above)

Name: _____ Phone:(H)_____ (W)_____ (C)_____

Relation: _____

Billing Address: _____

(if different from above) City State Zip

SS #: _____

Drivers License #: _____

Payment method : Check __ Credit Card __ May we keep this credit card on file for balance due?

Credit Card #: _____ Yes __ No __ (Please initial)

Exp ___ / ___

Emergency Contact

Whom should we contact? _____

Relation: _____

Home phone #: (____) _____

Work phone #: (____) _____

Cell phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

<u>Update</u>	
(Office use)	
_____	____/____/____
Initials	Date

Comments	
_____	____/____/____
Initials	Date

Comments	
_____	____/____/____
Initials	Date

Comments	