DENTAL CARE ASSOCIATES
3112 16th St. SW, St. A
Minot, ND 58701
701-852-0632

Patient Information

Patient's Legal Name: _____ Date: _____
First Middle Initial Last

Preferred Name: _____ SSN: _____ DOB: _____

Mailing Address: _____ **Sex:** Male ☐ Female ☐

_____ **Marital Status:** ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Child ☐ Separated
City State Zipcode

Cell Number: _____ Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Whom may we thank for referring you? _____

* Will only be used for office/patient communication & will be kept private.

Spouse Information

Spouse's Name: _____ Spouse's Phone: _____

Spouse's Employer: _____ Spouse's DOB: _____ SSN: _____

Responsible Party

Please fill out the following if the responsible party is someone other than the patient such as a parent/guardian. Otherwise, **please write "self."**

Legal Name: _____ Relationship: _____
First Middle Initial Last

DOB: _____ SSN: _____

Phone #: _____ Signature: _____

Additional Information

IN CASE OF EMERGENCY, CONTACT: _____ Relationship: _____

Cell Phone #: _____ Work Phone #: _____

Patient's Signature: _____

Parent/Guardian Signature: _____
(if patient is under 18 years of age