



PATIENT DEMOGRAPHIC INFORMATION

405 S. MARKET ST. - P. O. BOX 278
BENSON, N. C. 27504
TELEPHONE (919) 894-4195

PATIENT NAME _____
(FIRST - MIDDLE- LAST)

PREFERRED NAME _____

DATE OF BIRTH _____

MAILING ADDRESS

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

EMAIL _____

OCCUPATION/GRADE LEVEL _____

EMPLOYER/SCHOOL _____

PERSON RESPONSIBLE FOR ACCOUNT _____

EMERGENCY CONTACT NAME _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT PHONE _____

FOR COMPLETION BY PARENT/GUARDIAN IF PATIENT IS UNDER AGE OF 18:

PARENT/GUARDIAN #1 _____ RELATIONSHIP TO CHILD: _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

OCCUPATION: _____ EMAIL: _____

PARENT/GUARDIAN #1 _____ RELATIONSHIP TO CHILD: _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

OCCUPATION: _____ EMAIL: _____

BEST PHONE NUMBER TO CALL/TEXT FOR APPT REMINDERS: _____

Is there a favorite "something" we can talk to your child about? _____

Sometimes we make conversation by talking about upcoming holidays, cartoon characters, tooth fairy, etc. Is this ok with you? Please circle YES / NO

Sometimes we let children choose a cartoon or show to watch during treatment. Is this ok with you?

Please circle YES / NO