SOUTH LYON DENTAL CARE CENTER

Dr Paul Simon and Dr Kelly Rigney

Patient information Today's Date _____

Name _____ Preferred Name_____
Last First Middle

Date of Birth_____ SS#_____ Sex (circle one): M F

Address_____
Street Apt# City State Zip

Home Phone ( )_____ Cell Phone ( )_____

Work Phone ( )_____ Email _____

What is the best way for us to contact you?_____

Have you seen any other dentist or dental specialist in the last 12 months? (Circle One) Yes No

If yes, Who have you seen? _____

Whom may we thank for referring you? _____

Are you a full time student? (circle one) Yes No

Name and address of school you attend _____

If a minor, please provide the name(s) of the patient's parent(s) and/or legal guardian(s) below:

_____
Last First Relationship to patient Last First Relationship to patient

Spouse information

Name _____ Preferred Name _____
Last First Middle

Date of Birth _____ SS# _____

Person responsible for account

Complete this section only if the patient is under 18 years of age OR if the responsible party for this account is someone other than the patient.

Name _____ Preferred Name_____
Last First Middle

Date of Birth _____ SS # _____

Relationship to patient _____

By signing below, I agree to be responsible for all appointments as well as any treatment expenses or insurance co-payments for the above patient unless otherwise specified in writing.

_____
Signature of Responsible Party Today's Date