**Eastman Family Dental Center**

**421 Plaza. Ave**

**Eastman, GA 31023**

**(478) 374-4716**

**Patient's Name:** _____

**Patient's Parent, Guardian or Spouse:**_____

**Patient's Date of Birth:**_____ **Patient's SS#:**_____

**Patient's Mailing Address:**_____

_____

**Male**_____ **Female**_____ **Patient's Marital Status:**_____

**Patient's Employer:**_____

**Home Phone:**_____ **Business Phone:**_____

**Cell Phone:**_____ **Email:**_____

**How do you prefer to be contact to confirm your appointment? Phone**____ **Email**____

**Pt. Physician Name, Address, and Phone Number:**_____

_____

**Please list any members of your immediate family who are patients:**_____

**Please list the name, relationship, and phone numbers of a person <u>not living in your household</u> whom we would contact in case of an emergency:**

_____