ARGYLE FAMILY DENTAL

Dr. Ava Khodakhast

Patient Information

Date: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home#: _____ **Cell#:** _____

Work#:_____ **Occupation:**_____

Birthday:_____ **Sex: M**_____ **F**_____**SS#**_____

Single_____**Married**_____**Widowed**_____**Separtated**_____**Divorced**_____

Email: _____

Who is financially responsible for your dental treatment?_ _____

Who may we thank for referring you to our office? _____

Who may we contact in case of an emergency?_____

Phone: _____

How long has it been since your last dental visit? _____

Why did you leave your last dental office?_____

If you could change something about your smile, would you? _____

What is your favorite hobby? _____

Who do you admire the most? _____

Signature: _____

*** Please provide the front desk with a copy of your <u>DENTAL</u> insurance card and policy holder's name ***