Creighton UNIVERSITY
School of Dentistry

We are updating our records. Bring this form with you to your next Dental appointment.
ALL INFORMATION IS REQUIRED TO BE A PATIENT AT THE DENTAL SCHOOL.

Patient Information (Please Print)

*Patient Name _____
Last First Middle

*Birth date _____ ☐ Male ☐ Female *SSN# _____

*Address _____Apt #_____ City _____ State _____ Zip _____

*Cell Phone _____Email_____Home Phone _____Work Phone _____

How do you prefer to be contacted? Cell Phone _____Email _____Home Phone _____Work Phone _____

If you are a student, name of school/college _____

Emergency Contact

*Person to contact in case of emergency _____

*Phone _____ Relationship to Patient _____

Responsible Party

Relationship to Patient _____

Who is responsible for this account? _____

*Cell Phone _____Email_____Home Phone _____Work Phone _____

How do you prefer to be contacted? Cell Phone _____Email _____Home Phone _____Work Phone _____

S.S.# _____

Address _____Apt #_____ City _____ State _____ Zip _____

Birth date _____

Employers

Patient's Employer _____ Phone_____

Responsible Party's Employer _____ Phone_____

X _____
SIGNATURE OF PATIENT (OR PARENT IF A MINOR) DATE