Patient #: ____________
(for office use only)

7820 Ballantyne Commons Parkway #104
Charlotte, NC 28277
Website: harrelldentalimplantcenter.com
Phone: 704-206-1330

PATIENT INFORMATION

DATE____________________

FIRST NAME____________________LAST NAME____________________

PATIENT'S Date of birth____________________SS#____________________

IF CHILD PARENT OR GUARDIAN'S NAME____________________

ADDRESS 1____________________

ADDRESS 2____________________

CITY____________________STATE____________ZIP ____________

HOME PHONE____________________CELL____________________

Can we send you a text message? ☐ Yes or ☐ No

EMAIL ADDRESS: ____________________

BEST METHOD OF CONTACTING YOU:____________________

REFERRED BY:____________________

Why did you choose Harrell Dental Implant Center as your dental office?
____

EMPLOYER'S NAME: ____________________PHONE: ____________________

Occupation: ____________________

Has any member of your family been treated in our office previously? -- ☐ Yes/ ☐ No If yes, Relationship____________________

PLEASE CIRCLE— ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Responsible person for account: ☐ SELF
OTHER: PLEASE LIST:____________________SS#____________________

Emergency Contact Information:

Name____________________Relationship____________________

Contact Number: ____________________