Shah Orthodontics
Tarak V. Shah, D.D.S.

Patient Information (ADULT)

Name ____
First Middle Last

Birthdate _______________ Age_____ Gender M___ F___

Street Address ____

City ____ State_______________ Zip Code____________

Primary Phone Numbers (____) ____________________ (Cell) (____) ______________________(Home)

Email Address ____

I am currently: ____Single ____Married ___Partnership ____Separated ____Divorced ____Widowed

Occupation _________________________________ Employer ____________________________________

I am solely responsible for this account: ___yes ___no
If no, please provide name, address, and telephone number of responsible party: ______________________________

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Whom may we thank for referring you? ____

Hobbies/Interests ____

Emergency Information
Name of person to contact in case of emergency _____________________________________

Address ____

Phone (_____) ___________________ Relationship ___________________________________

General Dentist: ____ Phone: (_____) ____________________________

Primary Physician: ____ Phone: (_____) ____________________________

Chiropractor: ____ Phone: (_____) ____________________________

Purpose of your visit/main concern/long-term dental goals

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