SMILE
Wellness Co.

On behalf of Dr. Jolyn Su and our Dental Team, we are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. All information will be kept confidential.

Patient Information

Patient Name: _____ Preferred Name: _____
Last First M.I.

Title: _____ Gender: _____ Driver's License #: _____
Mr/Ms/Mrs/etc

Family Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Child

Date of Birth: _____ SS#: _____ Email:_____

Home Phone: (____) _____Work: (____) _____Mobile:(____)_____

Address: _____ City:_____ State:____ Zip:_____

Employer: _____ City: _____State: ____ Zip: _____

Emergency contact: _____Relationship: _____Phone:(____) _____

Whom may we thank for recommending our office to you? _____

Responsible Party Information

The following is for: ☐ Parent/Guardian ☐ Self ☐ Other _____
(If below information is the same as above please leave blank)

Name: _____Preferred Name:_____

Title: _____ Gender: ____ Driver's License #: _____
Mr/Ms/Mrs/etc

Date of Birth: _____SS#:_____Email:_____

Home Phone: (____) _____Work: (____)_____ Mobile: (____)_____

Address: _____City: _____ State: _____ Zip: _____

Employer: _____ City: _____ State: ___ Zip: _____