PORTO FINO
DENTAL
FAMILY, COSMETIC, & RESTORATIVE DENTISTRY

Demographics

First Name: _____ Last Name: _____

What name does the patient prefer to go by? _____

Gender: _____

Date of Birth: _____

SSN: _____

Email Address: _____

Phone Number: _____

Type: **Mobile ( )** **Home ( )**

Address Line 1: _____

Address Line 2: _____

City: _____

State/Province/Region: _____

Postal Code: _____

Who is filling out the form today? **Patient** ( ) **Family Member** ( ) **Other** ( )

Please provide your first and last name

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First Name: _____ Last Name: _____

Phone Number: _____

Who has legal custody of the patient? _____

Primary Contact Details - who should we contact for scheduling?

Primary Contact Name: _____

Relationship to Patient: _____

Phone Number: _____

Address Line 1: _____

Address Line 2: _____

City: _____

State/Province/Region: _____

Postal Code: _____

How did you hear about us? _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

YES / NO Is the patient also the guarantor?

Guarantor First Name: _____

Guarantor Last Name: _____

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Relationship to Patient: _____

Phone Number: _____

Email Address:

_____

Address Line 1:

_____

Address Line 2:

_____

City: _____

State/Province/Region: _____

Postal Code: _____

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EMPLOYMENT DETAILS

Occupation:

_____

How long? _____

Employer Name:

_____

Please list 2 contact names to whom practice can release PHI information (HIPAA)

First Name: _____

Last Name: _____

Phone Number: _____

First Name: _____

Last Name: _____

Phone Number: _____

EMERGENCY CONTACT

First Name: _____

Last Name: _____

Phone Number: _____

Email Address:

_____

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_____

Today's Date

_____

_____

Patient Print Name

Patient Signature