



South Main Dental, P.A.

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Chart # _____
For Office Use Only

Patient Information

Patient Name: _____
Last First MI Preferred Name

Address: _____
City State Zip

Date of Birth: _____ **Social Security #:** _____

Phone: _____
Home Mobile Work

For appointment reminders and other office notifications, it is OK to: Text Call Email

Email Address: _____

Family Status: Married Single Child Other **Sex:** Male Female

Emergency Contact: _____
Name Phone Number Relationship

Referred By/How did you find us: _____

Dental Insurance Subscriber Name: _____ **DOB:** _____

Are you interested in learning about our No Insurance, No Problem In-house Dental Savings Program? Yes No

Are you Interested in learning about other Financial Arrangement Options? Yes No

Do you have a custody agreement in place? Yes / No If so, who is financially responsible? _____