



PATIENT INFORMATION

Date: _____

SSN: ____-____-____

Birthday: _____

Gender: Male ☐ Female ☐

Patient's name: _____

Last

First

MI

Nickname

Mailing Address: _____

Street

City

State

ZIP

☐ I authorize the office of **Jacob O Layer, DMD, PC** to contact me and/or leave messages with confidential information at the following contact methods:

Home #: _____

Cell #: _____

Work #: _____

Email address: _____

I would like appointment reminders by: ☐ **Text** ☐ **Email**

Self or Primary Responsible Party ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other(specify) _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Years at this address? ____ Own ☐ Rent ☐

Employer: _____ Occupation: _____ Years Employed: _____

Social Security Number: ____-____-____ Date of Birth: _____

Marital Status: Married ☐ Single ☐ Divorced ☐

Spouse or Secondary Responsible Party ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other(specify) _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Years at this address? ____ Own ☐ Rent ☐

Employer: _____ Occupation: _____ Years Employed: _____

Social Security Number: ____-____-____ Date of Birth: _____

Marital Status: Married ☐ Single ☐ Divorced ☐

Emergency Contact Information

Primary:

Name: _____ Phone: _____

Address: _____

Secondary:

Name: _____ Phone: _____

Address: _____