Dental Health Partners

240 East 23rd Ave
Mitchell, SD 57301
605-996-1316

Patient Information

Patient Name____Date____________
Last First MI

(Preferred Name)________________________

- Male
- Female

□ Married □ Single □ Child □ Other

Birth Date________________ Social Security#__________________________

Address____
Street or PO Box City State Zip Code

Phone(Home)______________________________ (Work)__________________________

Employer_________________________________ Address_________________________

Spouse or Responsible Party Information

Name_____________________________________ □ Married □ Single □ Child □ Other
Last First MI

Birth Date____________________ Social Security #_______________ □ Male □ Female

Address____
Street or PO Box City State Zip Code

Phone (Home)______________________________ (Work)_________________________

Employer__________________________________Address_______________________

Emergency Contact Information

Name__________________________ Phone (Home)____________(Work)__________

Name__________________________ Phone (Home)____________(Work)__________

Referral Information

Whom may we thank for referring you to our practice? □ Another Patient(Name)________
□ Yellow Pages □ Newspaper □ School/Work, (Name)_________ □ Other ___________