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

Patient Information

Patient Name_____Date_____
Last First MI

(Preferred Name)_____

- Male □ Married □ Single □ Child □ Other
- Female

Birth Date_____ Social Security#_____

Address_____
Street or PO Box City State Zip Code

Phone(Home)_____ (Cell)_____

Employer_____ (Work)_____

Email 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 _____