ROY E. GAINES, JR., D.D.S., M.D., P.A.

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ M.I._____ Last Name_____ Nickname_____

Sex: ☐ Male ☐ Female Birth Date_____ Age _____ Soc.Sec. #_____

Street Address: _____ City _____

State _____ ZIP Code _____ E-mail _____

Home Tel: ( ) _____ Cell: ( ) _____

Have you ever been a patient of our practice? ☐ Yes ☐ No

Dentist:_____ Medical Doctor:_____ Referred By:_____

Driver's Lic.# _____ Nearest Relative not living with you: _____ Tel: ( )_____

Employer: _____ Bus. Tel.( ) _____

Personal Payment type: ☐ Cash ☐ Check ☐ Credit Card

Who will be responsible for your account? ☐ self ☐ spouse ☐ father ☐ mother ☐ other *(If self, skip to next section)*

First Name_____ M.I._____ Last Name_____ Nickname_____

Sex: ☐ Male ☐ Female Birth Date_____ Age_____ Soc.Sec. #_____

Address: _____

Home Tel: ( ) _____ Cell: ( ) _____

Employer: _____ Bus. Tel.( ) _____

Other Information

Student: ☐ Full Time ☐ Part Time ☐ Not School Name/ Address: _____

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not