

**New Patient Information
Welcome to Our Office**

**Hampton Roads Center for
Cosmetic Dentistry
Dr. Carol F. Morgan, DDS, PC**

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

I Prefer to be Called: _____ Date of Birth: ____ / ____ / ____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work: () _____ Cell: () _____

Email Address: _____ May we confirm appointment by email? YES NO

Male Female Marital Status: _____ Soc. Security No.: _____

Occupation: _____ Employer: _____

Employer Address: _____

May we call you at work if necessary? YES NO Direct Dial No.: () _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

Day Phone: () _____ Night Phone: () _____

REFERRAL INFORMATION:

Who May We Thank For Referring You to Us? _____

If Not Referred, How Did You Select Our Office? Infomercial Yellow Pages Mail Email Other

Are Any Other Members of Your Family Our Patients? _____

MEDICAL HISTORY:

Are You Currently Under the Care of a Physician? Yes No

If Yes, Please Explain: _____

Please List All Health Professionals Concerning Any Treatment Related To Jaw Pain or Headaches.

Practitioner	Specialty	Treatment and Approximate Dates
1: _____	_____	_____
2: _____	_____	_____
3: _____	_____	_____

