GRAY'S PERIODONTAL CENTER

Andrew K. Gray, PharmD, DDS, MDS

Gray's Periodontal Center
PERIODONTICS ■ IMPLANTS

PATIENT INFORMATION

Date: _____ ☐ Female

Name: _____ ☐ Male

Preferred Salutation or Nickname: _____

Date of Birth: _____ Social Security Number_____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address 1: _____

Email Address 2: _____

Phone (h)_____ Phone(c/w)_____

Patient Employer: _____ Occupation: _____

Business Address: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Business Address: _____ Phone (c/w): _____

Referring Dentist: _____ Phone or Email: _____

Primary Physician: _____ Phone or Email: _____

Emergency contact person: _____

Emergency contact phone numbers: _____

Who will be responsible for payment? ☐ Self ☐ Spous☐ Parent☐ Other

Method of Payment

Guarantee: *I understand that I am financially responsible for payment in full for all accounts of the patient listed on this form. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment in full for all services at the time they are rendered.*

Guarantor's Signature: _____ Date: _____