WILKES PUBLIC HEALTH
DENTAL CLINIC

***** Patient is required to notify office ASAP if contact information changes!**

DATE_____

PATIENT REGISTRATION

Home Phone_____ **Cell Phone**_____ **Work** _____

E-Mail Address _____

Alternate contact number of someone outside the home _____

Relationship _____

Patient _____
Last Name First Name Initial Preferred Name

Mailing Address _____ **County** _____

City _____ **State** _____ **Zip Code** _____

Birthdate _____ **Age**_____ **Social Security #** _____

Sex/Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female

Check Appropriate Box: ❑ Child ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Sexual Orientation: ❑ Lesbian or Gay ❑ Straight ❑ Bisexual ❑ Something Else
❑ Don't Know ❑ Choose Not To Disclose

Race: ❑ White, Non-Hispanic ❑ Black/African American ❑ Hispanic/Latino
❑ Asian/Pacific Islander ❑ American Indian, Eskimo or Aleut ❑ More Than One Race
❑ Unreported or Refused To Report

Language: ❑ English ❑ Spanish ❑ Chinese ❑ Russian ❑ Sign Language ❑ Other

Work Status: ❑ Employed ❑ Unemployed ❑ Disabled ❑ Retired ❑ Migrant ❑ Seasonal

Living Status: ❑ Temporary w/Another Family ❑ Homeless Shelter ❑ Street ❑ Transitional
❑ Group/Nursing Home ❑ Permanent Residence

Housing Statues: ❑ Public ❑ Non Public

Family Information (For Children Only)

Name of Parent _____
Circle one: Father Stepfather Guardian
Address _____
Home Phone_____Work Phone_____
E-Mail _____
Employer_____
SS#_____ Birthdate_____

Name of Parent _____
Circle one: Mother Stepmother Guardian
Address_____
Home Phone_____ Work Phone_____
E-Mail _____
Employer_____
SS#_____ Birthdate_____

Other Family Members That Are Patients _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my contact information and/or medical status. I authorize the dental staff to perform the necessary dental services.

_____ _____
Signature of Patient/Legal Guardian Date