BROOKWOOD
DENTAL CARE

Dr. Robert B. Connor, D.M.D
Dr. Samantha S. McCool, D.M.D

First Name: _____ Last Name:_____ MI:_____

Preferred Name: _____

Birth date: _____ Social Security #: _____

Patient Information:

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

E-mail: _____

Preferred contact method: ○ Call ○ Text ○ Email

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Preferred Dentist: _____ Preferred Hygienist: _____

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ MI: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Birth date: _____ Social Security #: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Preferred Dentist: _____ Preferred Hygienist: _____

Signature* Date*

_____ _____