GARDEN CITY smiles
DENTAL CLINIC

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General Patient Information: ***REG NO:***

☐Mr. ☐Mrs. ☐Ms. ☐Master ☐ Dr

First Name _____ Last Name_____ Middle Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____ BMI: _____

Address: _____

City: _____ State: _____ Country: _____ Pin: _____

Employed:☐ Public ☐ Private ☐NGO ☐Armed Forces Specify Details: _____

Retired: ☐ YES ☐NO If YES SPECIFY _____(Year, Post/Designation)

Mobile No: _____ Home Phone: _____ Email id: _____

Marital Status: ☐Married ☐Divorced ☐Single; Are you Pregnant: YES ☐ NO ☐ If YES,TRIMESTER _____

Are you a student: YES/NO. IF YES ☐ Full time ☐Part-time; Specify: PG/UG/PUC/SSLC / (Tick appropriate one)

Covid vaccination (Type, Date): _____ Booster Dose: _____

Emergency Contact details: (Name, Relationship, Mob No): _____

Reason for seeking appointment/ Chief Complaint: _____

_____

Dental History: _____

How did you hear about us: (Tick the most appropriate one)

- Physician Referral
- Dentist referral
- Physiotherapist referral
- Psychotherapist referral

social media (Google/Facebook/Instagram)
Print Media (Flyers/Pamphlets/ Newspaper)
Family/Friends
Walk-in

I _____, here by declare that the information furnished above is true, complete, and correct to the best of my knowledge and belief.

Signature: _____ & Date: _____

(Please note: Signature of PARENT/GUARDIAN: for individual below 18yrs or individuals with Limited manual dexterity)