



SAPPHIRE  
DENTAL  
PLLC

**PATIENT INFORMATION:**

Patient Legal Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Email: \_\_\_\_\_  
Employer: \_\_\_\_\_

How would you prefer to receive appointment confirmation?  
Voicemail \_\_\_\_\_ Text \_\_\_\_\_ Email \_\_\_\_\_

Who may we thank for referring? \_\_\_\_\_

Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_  
Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Married/ Single/ Divorced/ Minor/ Other  
Home: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Work: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_  
Emergency Contact Number: \_\_\_\_\_

**RESPONSIBLE PARTY: (if patient is a minor)**

Legal Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Married / Single / Divorced / Other: \_\_\_\_\_

Preferred Name: \_\_\_\_\_  
Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Cell #: \_\_\_\_\_  
Work #: \_\_\_\_\_

Legal Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Married / Single / Divorced / Other: \_\_\_\_\_

Preferred Name: \_\_\_\_\_  
Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Cell #: \_\_\_\_\_  
Work #: \_\_\_\_\_