Willamette Dental

Patient Information

NAME (LAST, FIRST, MIDDLE INITIAL)	PREFERRED NAME
ADDRESS	**PRONOUNS**
	☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Zirs ☐ Ze/Hir/Hirs
CITY, STATE, ZIP	**EMAIL ADDRESS**
MOBILE PHONE NUMBER	**PREFERRED CONTACT METHOD (PLEASE CHECK ONE)***
	☐ Email ☐ Text ☐ Phone ☐ Other

**You'll receive messages with important information from your dental team about your appointments and treatment through your preferred contact method.*

EMERGENCY CONTACT

NAME	RELATIONSHIP
PHONE	
ADDRESS	

MY RACE / ETHNICITY IDENTIFICATION IS:

(PLEASE CHECK ALL THAT APPLY)

- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ White/Caucasian
- ☐ Other (not listed)
- ☐ Decline to Answer

MY LANGUAGE PREFERENCE IS:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Chinese
- ☐ Other_____

GENDER:

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ I'd Rather Not Say/Unspecified
- ☐ Other_____

**This information helps us ensure that we are providing the highest quality of care for our patients. Studies have shown that racial/ethnic backgrounds may impact our patients' oral health risk for certain diseases. Recording patient data regarding race and ethnicity will allow Willamette Dental to better understand and meet our patients' oral health needs. As well, this information is not given away, sold, or used for anything other than Willamette Dental business.*

PREFERRED PHARMACY & PHYSICIAN

PHARMACY NAME	PHARMACY PHONE NUMBER
PHARMACY ADDRESS	
PHYSICIAN NAME	**PHYSICIAN PHONE NUMBER**