

PATIENT INFORMATION

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| NAME (LAST, FIRST, MIDDLE INITIAL) | PREFERRED NAME |
| ADDRESS | PRONOUNS <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Ze/Zir/Zirs |
| CITY, STATE, ZIP | EMAIL ADDRESS |
| MOBILE PHONE NUMBER | PREFERRED CONTACT METHOD (PLEASE CHECK ONE)* <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/> 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 Group 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 Group business.

PREFERRED PHARMACY & PHYSICIAN

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|------------------|------------------------|
| PHARMACY NAME | PHARMACY PHONE NUMBER |
| PHARMACY ADDRESS | |
| PHYSICIAN NAME | PHYSICIAN PHONE NUMBER |