# John E. Truitt, D.D.S, P.C.

## Patient Information

Chart #_____(office use only) Today's Date_____

Patient's Name_____

Name you like to be called_____ Sex: Male Female

Address_____

City/State_____Zip_____

Home Phone_____Cell Phone_____

SS#_____Marital Status_____ Date of Birth_____

Employer_____Occupation_____Work Phone_____

Name of Dentist_____Name of Physician_____

Whom can we thank for recommending you to our office?_____

Other family members treated by Dr. Truitt_____

## Person Financially Responsible for this Account

Name:_____Relationship to Patient_____

Address:_____City/State_____Zip_____

Home Phone_____Cell Phone_____SS#_____

Employer_____Work Phone_____

Signature of Responsible Party:_____Date:_____