SOUTHSIDE DENTAL LTD

GENERAL INFORMATION OF PATIENT

All questions contained in this questionnaire are strictly confidential and will become part of your dental record.

Date

Name *(Last, First, M.I.)*:		**Sex: ☐ M ☐ F**
Chinese Name (中文姓名):	**Hong Kong ID No:**	
Date of Birth:	**Age:**	
Home address:		
Phone No: (Home)	**(Mobile)**	**(Office)**
Email:		
Preferred contact method (tick applicable, one or more): **☐ Home Phone No ☐ Mobile Phone No ☐ Office Phone No ☐ Email**		
Occupation:		
Name of Company:		
Father's Name:		
Mother's Name:		
Name of Bother(s) and/or sister(s):		
School:	**Grade:**	
Patient's Dentist:		
Referred By:		
Person responsible for payment:		
What is your chief concern in seeking orthodontic care?		