

**WILLIAM V. DOUGHERTY III, D.D.S.**

**PATIENT INFORMATION**

Date \_\_\_\_\_  
Name (first, middle initial, last) \_\_\_\_\_  
Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Please check one: Single \_\_\_\_\_ Married \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_  
Optional: Fax \_\_\_\_\_ Pager \_\_\_\_\_  
Email \_\_\_\_\_

In case of emergency please list two contacts:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Dougherty or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Patient or Guardian)

