



Central Houston
Oral & Implant Surgery
Dr. Phillip A. Kattchee DDS, PA

Patient Registration

Date: _____

Patient's Name: _____ Birth Date: _____

Home Address: _____ Age: _____

City, State, Zip: _____ Home Tel #: _____

Driver's License #: _____ Cell #: _____

Email Address: _____

Sex: (M) (F) Marital Status: Single Married Widowed Separated Divorced

Employer's Name: _____ How Long: _____

Address: _____ Occupation: _____

City, State, Zip: _____ Work#: _____

Spouse's/Partner's Name: _____

Spouse's/Partner's Employer and Address: _____

Spouse's/Partner's Work# _____

Attention: Minor Children will **not** be seen without a parent or legal guardian **present**

(Relatives must have a legal power of attorney.)

Parent/Legal Guardian Information

Parent/Legal Guardian Name: _____

Address: _____ Home/Cell#: _____

City, State, Zip: _____ Work#: _____

Parent/Legal Guardian TDL#: _____ Birth Date: _____

Referred to Dr. Kattchee by: _____

In case of an emergency who do we contact: _____

Telephone: _____

Name of closest relative **not** living with you: _____

Address: _____ Phone#: _____