



## A WINNING SMILE DENTAL CENTER

Greg C. Witte, D.M.D.  
5417 Robbs Lane • Louisville, KY 40219  
(502) 969-9897  
www.PerfectWinningSmile.com

### PATIENT ACQUAINTANCE

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street  
City State Zip Sex M F

E-Mail Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Home Phone \_\_\_\_\_ Marital Status S M D W O

Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(if applicable)

Spouse's Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Person to Contact in Emergency \_\_\_\_\_ Phone # \_\_\_\_\_  
other than spouse

How did you hear about our office? Friend Relative Other

As we appreciate all our referrals, please list \_\_\_\_\_

#### Acknowledgement:

I consent to treatment as necessary or desirable for the care of the patient named above, including but not limited to x-rays, drugs, medicine, performance of treatment and use of lab, x-rays or other studies that may be used by Dr. Witte or his staff. I acknowledge full responsibility for the payment of service and agree to pay AT TIME OF SERVICE unless other arrangements are made prior to the time of service.

Signed \_\_\_\_\_  
Must be 18 years or older