Best way to reach you?
☐ Home ☐ Work
☐ Cell ☐ Text
☐ Email

WELCOME TO OUR OFFICE

PATIENT INFORMATION (CONFIDENTIAL)

DATE_____

NAME_____ FEMALE ☐ MALE ☐
first last

ADDRESS_____CITY_____STATE_____ZIP_____

E-MAIL_____CELL#_____HOME#_____

WORK#_____SS#_____BIRTHDATE_____

CIRCLE APPROPRIATE ONE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED DOMESTIC PARTNER

IF COLLEGE STUDENT, CIRCLE ONE **F.T. / P.T.** NAME OF SCHOOL_____

CITY_____STATE_____ZIP_____

SPOUSE OR PARENT'S/GUARDIAN'S NAME_____

WORK#_____WHO MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE_____
(someone not in your household)

RELATIONSHIP_____

RESPONSIBLE PERSON FOR ACCOUNT

RESPONSIBLE PARTY_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME#_____CELL PHONE_____E-MAIL_____

DRIVER'S LICENSE #_____BIRTHDATE_____SS#_____

EMPLOYER_____WORK #_____

IS IT O.K. TO BE CONTACTED AT WORK? YES NO

WHOM MAY WE TALK TO ABOUT YOUR ACCOUNT?_____

WHO MAY WE TALK TO ABOUT YOUR TREATMENT?_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP_____

SS#_____BIRTHDATE_____EMPLOYER_____

INS. CO._____TEL#_____

GROUP#_____POLICY#_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED_____RELATIONSHIP_____

SS#_____BIRTHDATE_____EMPLOYER_____

INS. CO._____TEL#_____

GROUP#_____POLICY#_____

X_____ _____
Signature of Patient or Parent/Guardian Date

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient's name)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's
Signature_____Date_____

Parent/Responsible Party's Signature_____

Relationship to Patient_____