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☐ Cell	☐ Text
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Welcome to Our Office

GREEN VALLEY DENTISTRY
E. Bedolla, DDS & J. Cook, DDS

PATIENT INFORMATION

DATE _____

NAME _____ ☐ Female ☐ Male
(first) (last)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL# _____ HOME # _____

WORK# _____ SS# _____ BIRTH DATE _____

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

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ PHONE # _____

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 / PAYMENT

☐ SELF ☐ OTHER NAME _____

DRIVER'S LICENSE # _____

EMPLOYER _____ WORK # _____

DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP _____

SS# _____ BIRTH DATE _____ EMPLOYER _____

INS. CO. _____ PHONE # _____

GROUP # _____ POLICY # _____

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

NAME OF INSURED _____ RELATIONSHIP _____

SS# _____ BIRTH DATE _____ EMPLOYER _____

_____

INS. CO. _____ PHONE # _____

GROUP # _____ POLICY # _____

SIGNATURE _____ DATE _____
(Signature of Patient or Parent / Guardian)

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 full 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 _____