

Patients Information

Last Name: _____ First Name: _____

Preferred Name: _____

Address: _____

Best Phone Number to Reach You: _____

Alternative Phone Numbers: _____

E-mail Address: _____

Marital Status: _____

Date of Birth: _____ Age: _____ SS# _____ Driver License # _____

Employer/School Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Name of Your Physician: _____ Phone Number: _____

Whom may we thank for referring you to our office? Friend/Patient: _____

Insurance: _____ Internet: _____ Ad/ Flyer: _____ Other: _____

If you are completing this form for another person, what is your relationship to that person?

Name: _____ Relationship: _____ Phone Number: _____

Patient Consent

The undersigned hereby authorizes Doctor to take X-rays (radiographs), study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, therapy, and medication that may be indicated in connection with patient and further authorize and consent that the Doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1 and 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to collect this note.

Patient's Signature: _____ Date: _____