PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please Print. All information will be confidential.

PATIENT INFORMATION

Today's Date: _____/_____/_____

Last Name: ______________________________ First Name: ______________________________ MI____

Nick Name: ____________________ Date of Birth: ____/____/____ Age: ______ ____Male __Female

Address: ______________________________ City: ____________________ State: _____ Zip Code: __________

Child's Home Phone #: ____________________

PARENT/GUARDIAN INFORMATION

__Mother __Father __Step Mother __Step Father __Legal Guardian

Parent/Guardian Marital Status: __Married __Divorced __Separated __Widowed __Single

Name: ______________________________ Email: ______________________________

Date of Birth: _____/_____/_____ Social Security #: _________-_________-_________

Address: ______________________________ City: ____________________ State______ Zip Code: __________

Home #: ____________________ Cell #: ____________________ Work #: ____________________

Employer: ____________________ Occupation: ____________________

__Mother __Father __Step Mother __Step Father __Legal Guardian

Parent/Guardian Marital Status: __Married __Divorced __Separated __Widowed __Single

Name: ______________________________ Email: ______________________________

Date of Birth: _____/_____/_____ Social Security #: _________-_________-_________

Address: ______________________________ City: ____________________ State______ Zip Code: __________

Home #: ____________________ Cell #: ____________________ Work #: ____________________

Employer: ____________________ Occupation: ____________________

Other Children in Family (Names and Ages):

Purpose of visit:

How did you hear of us:

CONSENT:

1. I agree that all the above information is true and correct, and I understand that it is my responsibility to advise this office of any changes in the information contained on this form.
2. The undersigned hereby authorizes the taking of x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my child's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy for such treatment. I understand using anesthetic agents embodies a certain risk.
3. I understand that all responsibility for payment of dental services provided by this office for my child is mine. Payments are due and payable at time services are rendered unless other arrangements have been made.

______________________________ ______________________________

Parent/Guardian Signature **Today's Date**