

PATIENT INFORMATION

(Please feel free to ask if you have questions)

REFERRAL SOURCE

Name of person who told you about us _____
Yellow Pages? Which One? _____
Other? _____

What do you expect from us today? _____

Why did you leave your last dentist? _____

What did you like least about any previous dentist? _____

What did you like most about any previous dentist? _____

PATIENT INFORMATION

Name _____	Social Security# _____
Address _____	Phone (H) _____ (W) _____
City/State _____	How long at this address? _____
Zip _____	Date of Birth (DOB) _____ male\female (circle one)
Employer _____	How long at this employer? _____
Employer Address _____	
Insurance Company _____	Agreement/Policy # _____
Group # _____	Union _____
Spouse _____	Social Security# _____ DOB _____
Employer _____	How long? _____
Insurance Company _____	Agreement/Policy # _____
Group # _____	Union _____

ACKNOWLEDGMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. Information about me and my treatment will be shared only as needed in the normal course of business and treatment.

Signed: _____ **Date** _____

I authorize the use of radiographs and/or photographs and/or descriptions of my treatment in presentations or publications of the doctor. My identity will not be revealed.

Signed: _____ **Date** _____

(over please-medical history on reverse side)