

PATIENT INFORMATION

DATE _____

NAME _____
Last First M
Married Single Minor Male Female SS# _____

ADDRESS _____ DL# _____

CITY/STATE/ZIP _____

BIRTHDATE _____ TELEPHONE _____
Month/Day/Year Home# Work# Cell#

PLACE OF EMPLOYMENT _____

ADDRESS _____

CITY/STATE/ZIP _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: _____ Patient _____ Guardian _____ Spouse _____ Parent

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED IN OUR OFFICE? _____ Yes _____ No

PERSON TO CONTACT IN CASE OF EMERGENCY (OUTSIDE IMMEDIATE FAMILY)

NAME _____

TELEPHONE # _____
Home# Work# Cell#

EMAIL ADDRESS _____

Whom may we thank for referring you to our office? _____

CONSENT FOR DENTAL CONSULTATION AND RADIOGRAPHS

A dental radiograph (x-ray) examination is one of the most important diagnostic tools your dentist uses to determine the presence of any dental disease and help you prevent dental diseases. Dental films enable the dentist to see inside bone and into the spaces between your teeth where even the smallest instrument cannot probe. Despite the preventative measures taken today by conscientious dentists and patients, problems can still develop in and around your teeth and supporting bone.

You want the best possible care. Your dentist can give you the best care only with the help of a dental radiographic examination. With the aid of dental films, your dentist can often detect conditions that—if left untreated—would eventually affect the function and appearance of your teeth as well as your overall health.

I hereby give Dr. Jamie Gomez my consent for dental consultation and radiographs. I have been informed of the reasons for radiographs. I also agree to accept financial responsibility for the treatment.

I authorize release of any and all information: radiographs, photographs, and models. I also understand they may be used for illustration and for documentation of my treatment

Signature of Responsible Party

Date