

Any other condition(s) not listed

IN CASE OF AN EMERGENCY, please contact _____

Relationship to patient _____

Address _____ Home Phone _____

Other Phone _____

What is the reason for your visit today? _____

Are you having any discomfort at this time? _____

Is there anything you would like to change about your smile? _____

What obstacles may prevent you from maintaining healthy teeth and gums?

TIME/ COST/ FEAR of PAIN/ OTHER

To make your visits more enjoyable

- Many patients choose to be sedated for "Sleep Dentistry"
- We have Nitrous Oxide/ laughing gas
- We use a computerized anesthetic delivery system to make numbing more comfortable.
- We have a large selection of music available to enjoy
- Our hygiene chairs have massage pads for our comfort
- We offer bottled water, coffee and juice

CONSENT:

This is to certify that I, the undersigned, consent to the performing of dental procedures mutually agreed to be necessary or advisable, including the use of a sedative or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. I hereby authorize the release of my dental records to any dental office to which I am referred for treatment by Dr. Cook or to any designated person at the patient's personal request.

PATIENT'S (PARENT'S) SIGNATURE _____ **TODAY'S DATE** _____

ANTHONY M.
COOK, D.D.S.

General & Cosmetic Dentistry

7805 Waters Avenue, Savannah, Georgia 31406

Records Release Request

(If applicable)

Date _____

To _____

Address _____

City _____ State _____ Zip _____

I authorize the release of dental record and x-rays and request they be sent to Anthony M. Cook D.D.S.

(Print name)

(Sign name)