St. Mary Dental

Patient Name: ______________________________________ CONFIDENTIAL
DOB: _____________ Chart #: _____________

Patient Information

Date _____________ Driver's Lic. /ID #__________ State Issued: _____ Social Security ____________________

□Mr. □Mrs.
□Miss □Ms. Name: ____ Birth Date _____/______/________
First *Middle* *Last*

Address:____
City *State* *ZIP*

Home Ph. (_____) ________________ Work Ph. (_____) ______________ Cell Ph. (_____) __________________

E-mail Address: ____

Check Appropriate Box: □ Minor □Single □ Married □ Divorced □ Widowed □ Separated

Patient's Employer: ____

Employer's Address: ____
City *State* *Zip*

Emergency Contact: ____ Ph. (_____) __________________________

Whom may we thank for referring you to our practice? □ Patient □ Dental Office □Other ___________________

Name of referring person or office ____

Parent / Legal Guardian

Name of person responsible for this account: ____

Relationship to Patient _____________ Driver's Lic # ________ State Issued: ___ Social Security #______________

Address ____
City *State* *ZIP*

Home Ph. (_____) ______________ Work Ph. (_____) _______________ Cell Ph. (_____) ____________________

Birth Date ______/_______/________ Employer: ____

Business Address: ____
City *State* *ZIP*

Assignment & Release

Please Initial.

_______I hereby authorize Dr. Basta and/or St. Mary Dental staff to take x-rays, study models, photographs (frontal and side profile images, intra oral images), and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs or my minor child's dental needs.

_______Upon such diagnosis I authorize Dr. Basta and/or associates to perform all recommended treatments mutually agreed upon to provide proper care.

_______I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that anesthetic agents embody certain risks. I understand that I can ask for a complete recital of any possible complications.

_______I hereby authorize and consent to the use of photographs and x-rays taken of me or my minor child and grant Dr. Basta permission to reproduce, publish, print, use, and distribute copies either in official medical publications or in the form of prints, slides or film for use in connection with articles, lectures, television broadcasts or advertising dealing with jaw or dental disorders. I waive any claims for invasion of privacy or monetary compensation.

_______I understand that payment is due at time of service unless prior financial arrangements have been made. I also understand that in the event payments are not received by agreed upon dates a 1 ½ % late charge may be added to my account monthly (18% APR). I agree to be responsible for payment of all services rendered on my behalf or that of any dependents.

____ ______________________________
Patient, Parent or Legal Guardian Signature Date