



St. Mary Dental

CONFIDENTIAL

Patient Name: _____

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 1/2 % 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