Date : _____

GETTING TO KNOW YOU AS OUR PATIENT

PLEASE ANSWER ALL QUESTIONS THOROUGHLY

PATIENT NAME **NICKNAME**	**SOCIAL SECURITY NUMBER**	**HOME PHONE** ( )
HOME ADDRESS	CITY, STATE, ZIP	BIRTHDAY / /
MARITAL STATUS ☐ Single ☐ Married ☐ Other	CELL PHONE ( )	EMAIL ADDRESS
EMPLOYER	OCCUPATION	WORK PHONE ( )
Primary Insurance Company _____ Group_____ Subscriber _____ Secondary Insurance Company _____ Group_____ Subscriber _____		

Responsible Party (If same as above information, please leave it blank)

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
HOME ADDRESS	CITY, STATE, ZIP	BIRTHDAY / /
RELATIONSHIP TO PATIENT	EMPLOYER	OCCUPATION

In Case of Emergency

NAME	RELATIONSHIP	HOME PHONE ( )
NAME	RELATIONSHIP	HOME PHONE ( )

How did you hear about our office? _____
If you were referred, whom may we thank for referring you? _____
What are your dental priorities? _____
(e.g.: apprentice, dental health, financial considerations, etc.)

CONSENT

- I will answer all health questions to the best of my knowledge _____
  Initial
- I hereby grant permission to Dr. Arash Aflatooni to employ such established treatments and therapy as may be deemed professionally necessary or advisable.
  For most procedures, local anesthetic administered. Risks involved may include the following: Heart palpitation, allergic reaction, hematoma, paresthesia, and/or drug cross-reaction. _____
  Initial
- Financial Agreement: All Charges for services and treatment will be paid upon completion of appointment. All outstanding balances over 90 days shall accrue interest at the rate of 1% per month. If insurance is involved: I hereby authorize payment directly to Advanced Dental Care otherwise payable to me. I hereby certify that the above information is true and correct.

Signed _____ Date _____

THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED 48 HOURS BEFORE THE APPOINTMENT TIME.