

AZ FAMILY DENTISTRY

Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Please Circle

Name _____ Male Female Soc. Sec # _____
Address _____ City _____ State _____ Zip _____
Birth date _____ Home # _____ Work # _____ Cell # _____
Other #'s _____ E-mail _____
Circle Appropriate: Minor Single Married Divorced Widowed Separated
Patient's or Parents Employer _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____
If patient is a student, name of school/college _____ City _____ State _____
How did you hear about us? _____ Reason for leaving last dentist _____
Last dental X-rays _____ Last visit to dentist _____ Person to contact in case of emergency _____
Relationship _____ Phone _____
Has any other family member been in office? (Please circle) YES NO If yes, name _____

RESPONSIBLE PARTY

Relationship to Patient (circle one)

Name of Person responsible for this Account _____ SELF SPOUSE CHILD OTHER
Address _____ City _____ State _____ Zip _____
Driver's License # _____ Birth date _____
Home # _____ Work # _____
Is this person currently a patient in our office? Please Circle YES NO

INSURANCE INFORMATION

ID# _____

Relationship to Patient (circle one)

Name of Insured _____ SELF SPOUSE CHILD OTHER
Birth date _____ Soc. Sec. # _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Phone # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
***Do you have additional insurance?** (Please circle) YES NO *If yes, please complete the following:* Relationship to Patient (circle one)
Name of Insured _____ SELF SPOUSE CHILD OTHER
Birth date _____ Soc. Sec. # _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Phone # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

CONSENT

- I understand and hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I understand and authorize doctor to perform all recommend treatment mutually agrees upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ assistance as deemed fit to provide recommended treatment.
- I understand that if a minor is being treated for any dental service, that, an authorized adult must stay on the premises at all times during the reserved appointment time. I also understand that if an adult or minor is being treated for dental services, no other minors will be allowed to accompany them during the treatment.
- I understand that it is my responsibility to advice and notify AZ Family Dentistry of any changes in the information contained on this form.
- To the best of my knowledge the information provided on this page is true.

Patient _____ Date _____
Parent or Responsible Party _____ Relationship to Patient _____