



Patient Name _____ Preferred Name _____ Date of Birth _____

Age _____ SSN _____ Sex _____ School/Grade _____

Street Address _____ City, State & Zip _____

Circle preferred phone number for us to leave a detailed message

Home Phone _____ Cell Phone _____

Name of Last Dentist Seen _____ Date Last Seen _____

Parent/Guardian Email Address _____

I would like valuable health information sent to me via email: YES NO

Mother's Name _____ Mother's Phone _____

Mother's Address (if different from child) _____

City, State _____ Zip _____

Father's Name _____ Father's Phone _____

Father's Address (if different from child) _____

City, State _____ Zip _____

Name of nearest relative not living with you _____ Relationship _____

Relative's Address _____ City, State, Zip _____

Phone Number _____

Name of Primary Care Physician: _____ Phone _____

Preferred Pharmacy _____

I hereby certify that the above information is correct to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

I understand that today's services will be only for a consultation or treatment of an emergency or urgent need. Any future treatment will require a comprehensive examination, x-rays as needed, and a treatment plan with consultation. I will not be considered a patient of record unless the examination is completed within 45 days and I pursue active patient care, as recommended. Additional emergency service is available only to active patients of record who have completed a comprehensive exam and the necessary diagnostic records.

I authorize members of the team at Port Warwick Dental Arts to leave a detailed message on my answering machine/voice mail.

I understand the above agreement, and consent to the recommended evaluation and/or treatment.

I hereby authorize Port Warwick Dental Arts and members of its team to assist in performing dental treatment necessary in my care or the care of my dependent. These services may consist of, but are not necessarily limited to: x-ray examination, photographic documentation, restoration of broken or decayed teeth, administration of local anesthetic, root canal therapy, periodontal (gum) therapy, prosthetic placement of missing teeth, orthodontic tooth movement therapy, surgical extraction of teeth and other diagnostic, surgical, cosmetic and restorative procedures, as needed and/or requested by me.

I understand that the procedures to be performed are recommended in an effort to bring my (or my dependent's) teeth, oral soft tissues and supporting structures into a state of maximum health. I have been given the opportunity to discuss possible alternative treatments, if such exist and understand that dental procedures may have potential risks. I understand that in health care, the success of treatment is the result of numerous factors which include the patient's present state of dental and total body health, the degree to which a state of disease has progressed, physical or psychological tolerance for the procedures, techniques and materials used, compliance with the post-operative instructions, as well as other factors which may be exclusive of the treatment rendered.

I certify that I read and write English and I have fully read and understood the preceding text as well as other medical and dental forms and have been given the opportunity to ask questions regarding treatment and this consent form. If I do not read or write English, an individual acting as my translator has helped me understand all necessary communications.

Patient/Guardian Signature _____ Date: _____

Staff Signature _____ Date: _____

FOR OFFICE USE:

Doctor notes, Findings, Treatment Recommended

Scale of 1-10 _____

Referral Source _____

Health – Time – Esthetics – Function