

PATIENT INFORMATION

Date: _____

➤ Patient Name _____
Last (Miss, Mrs., Mr., Dr.) First M Initial

Date of Birth _____ Social Security Number _____

Residence Address _____
Street City State Zip Code

E-mail Address _____

Residence Phone () _____ Work Phone () _____

➤ Employer _____ Position _____

Employer Address _____
Street City State Zip Code

➤ Name of Spouse _____
Last (Miss, Mrs., Mr., Dr.) First M. Initial

Spouse Employer _____ Position _____

➤ Person to call in case of emergency _____ Telephone No. _____

➤ I Prefer to have correspondence mailed to: Home Office Other (Please indicate)

PAYMENT OF CHARGES IS DUE AT THE TIME SERVICE IS RENDERED → PLEASE INDICATE PREFERRED METHOD				
<input type="checkbox"/> CASH	<input type="checkbox"/> CHECK	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS

➤ Do you have DENTAL Insurance: Yes No

➤ Person responsible for payment (Guarantor) if other than the patient.

Guarantor's Name _____ Social Security Number _____

Guarantor's Address _____
Street City State Zip Code

Guarantor's Residence Phone () _____ Work Phone () _____

Relationship to Patient _____

➤ By whom were you referred: _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes Dr. Boatwright to take x-rays, impressions for diagnostic casts, photographs or any other diagnostic procedures deemed necessary to make a thorough diagnosis of the patients' oral health. I also authorize Dr. Boatwright to perform any and all forms of dental treatment, to use any and all dental materials and to administer medications and therapy which may be indicated. I understand that the use of anesthetic or analgesic agents embodies a certain risk.

The undersigned also accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court cost if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Florida, or any other state.

I further authorize Dr. Boatwright to employ such auxiliary personnel as may be necessary to perform diagnostic, therapeutic and laboratory procedures.

PATIENT _____ DATE _____

PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP _____

CONSENT TO BE PHOTOGRAPHED

As Dr. Boatwright is committed to furthering the quality of dental education through teaching and writing, I authorize Dr. Boatwright to take or record slides, photographs or videotapes of the patient for the purpose of teaching, publication or research. It is understood that any photograph which depicts enough of the patient's face for the patient to be recognized shall be done only with the expressed written permission of the patient.

PATIENT _____ DATE _____

PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP _____