PATIENT INFORMATION

Patient Name	Date of Birth	Nickname (if any)	Gender
			M F
			M F
			M F
			M F
			M F

Address _____ City _____ST_____ Zip _____

Home Phone (_____) _____

Mother/Legal Guardian's:

Name_____

Employer _____

Work Phone _____ DOB: _____

Cell Phone_____

SS#_____

Father's/Legal Guardian's:

Name_____

Employer _____

Work Phone _____ DOB: _____

Cell Phone_____

SS#_____

Parents Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Which cell phone number do you prefer for text message appointment reminders?

Mom's Cell: ☐ Dad's Cell: ☐ Other ☐_____

Which e-mail do you prefer for e-mail appointment reminders? _____

How did you hear about our office? ☐ Internet ☐ Insurance ☐ Driving By ☐ Event ☐ Mailer
☐ Dr. /Person _____ ☐ Other_____

EMERGENCY CONTACT (AFTER PARENTS)

In The Event Of An Emergency, Who Should We Contact?

1) Name _____Relationship to Patient _____Phone _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Lisa Ameer and her staff to perform cleanings, exams and place topical fluoride treatments on my child. I request and authorize dental x-rays to be taken on my child as considered necessary by Dr. Lisa Ameer to diagnose and/or treat my child's dental needs. I acknowledge that I have been explained all the behavior management techniques that may be used with my child while experiencing dental treatment. I have been given the opportunity to discuss any questions that I may have.

I am permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for the dental treatment of this child. (Documentation may be requested from you regarding rights of parental consent for the child).

☐ Yes ☐ No

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Printed Name _____