Port Warwick
DENTAL ARTS
COMPREHENSIVE DENTISTRY FOR TOTAL WELLNESS, FUNCTION AND BEAUTY

Adult Patient Registration

Patient Name_____ Preferred Name_____ Date of Birth_____

Age_____ SSN_____ Sex_____ Marital Status_____

Street Address _____ City, State & Zip _____

Circle preferred phone number for us to leave a detailed message

Home Phone _____Work Phone _____ Cell Phone_____

Name of Last Dentist Seen_____ Date Last Seen_____

Email Address_____

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

Occupation_____Employer_____

Employer Address_____

City, State_____Zip_____Employer Phone_____

Spouse Information (if applicable)

Full Name_____ Date of Birth_____

Occupation_____Employer_____

Employer Address_____ City, State, Zip_____

Employer Phone_____

Name of nearest relative not living with you_____ Relationship_____

Relative's Address_____City, State, Zip_____

Phone Number_____

Military Information (if applicable)

Member Rank Unit_____Station_____ Length of time at current address_____

Name of Primary Care Physician: _____ Phone_____

Preferred Pharmacy_____

Emergency Contact Name_____ Relationship_____ Phone_____

If a minor, Parent/Guardian info:

Name_____ SSN_____DOB_____

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

Patient 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