EDMONDS DENTAL STUDIO

Advanced Implant and Cosmetic Dentistry

PATIENT REGISTRATION

PATIENT INFORMATION Date

Patient name	Preferred name	
Address		
City	State	Zip
Birth date	Weight	
Home phone	Cell phone	
Business phone	Employer	
Email address		

May we leave detailed phone message at the above phone numbers: Yes ◯ No ◯

ACCOUNT INFORMATION

Person responsible for account		
Address		
City	State	Zip
Birthdate Occupation	Employer	
Employers address		
City	State	Zip
Spouse of person responsible for account		
Spouse's employer		

GETTING TO KNOW YOU

Were you referred to us by one of our patients? Yes ◯ No ◯	
If yes, whom may we thank?	If no, how did you find us?
Is another member of your family, or relative, a patient in our practice?	
Person to contact for emergency	Phone
Closest relative not living with you	Phone

RELEASE

I consent to the making of photographs and radiographs before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. My name and other identifying information will be kept confidential. Certain photographs will be required, however these are used for clinical information and are necessary for treatment documentation.

***24 hours notice is required for canceling or changing appointments.**

I certify I have read or had read to me the contents of this form.

Signature: _____ Date: _____

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