BRANDON PERIO CLINIC
CERTIFIED SPECIALIST IN PERIODONTICS

PERSONAL HISTORY

Mr. Mrs. Ms. Dr. Miss Mstr.

Patient Name _____
First Middle Last

Address: _____ Phone_____ (H)
_____ _____ (W)
_____ _____ (cell)
City Province Postal Code

E-mail _____

How would you prefer to be contacted: home work cell email

Date of Birth _____ Occupation_____
Day/Month/Year
Parent or Guardian (if under 18) _____Phone _____ (H)
_____ (cell)
Emergency Contact: _____
Name Phone
Name of Dentist _____

Who may we thank for referring you to this office? _____

Physician _____ Phone _____

FINANCIAL RESPONSIBILITY

Payment is required at the time service is rendered. We are happy to provide you with an estimate. You may pay your account by Cash, Visa, M/C, Amex, and Debit. The following dental insurance information helps us assist you in better utilizing your insurance benefits.

Do you have dental insurance? YES NO

Insurance Carrier Name: _____Group No. _____ID No._____

CONSENT

I authorize the dental personnel to perform services for the prevention, diagnosis and treatment of periodontal disease using the procedures and medications required, and assume responsibility for the fees associated with those procedures.

Date _____ Signature of Patient or Parent _____