WELCOME TO OUR PRACTICE!

PLEASE FILL OUT THE INFORMATION BELOW:

Patient Name_____

Child: Parent's Name _____

How do you wish to be addressed? _____

☐Single ☐Married ☐Minor

Address_____

City_____ State____ Zip_____

Business Address _____

Phone: Res _____ Business_____

Cell_____Fax_____

Employed by _____

Present Position _____

How long held _____

Spouse Name _____

Employed by _____

Who is responsible for this account _____

Drivers License No _____

Method of payment ☐Insurance ☐Cash/Check ☐Credit card

Purpose of visit today _____

Other family members at this Practice _____

How did you hear about our office?_____

In case of emergency call _____

Phone _____ Relation _____

Sharen C. Strong, D.M.D.

General Dentistry
Personalized and Comfortable Dental Care
155 Delaware Ave., Bandon, OR 97411
541-347-5555 Fax 541-347-5145

Age _____ ☐Male ☐Female

Date of Birth_____

Social Security No _____

PRIMARY INSURANCE

Insurance Company_____

Policy No _____

SECONDARY INSURANCE

Insurance Company_____

Policy No _____

AUTHORIZATION/CONSENT TO TREATMENT

I hereby authorize Dr. Sharen C. Strong DMD or her staff to perform dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition, including dental x-rays and administering of local anaesthetics. I understand that any dental treatment involves certain risks. If I wish to have a more detailed explanation of the diagnosis, treatment risks or alternatives to treatment, I will ask for such.
I consent to Dr. Strong's use and disclosure of my records to carry out treatment and to obtain payment.

FINANCIAL RESPONSIBILITY

I authorize payment directly to Dr. Strong of insurance benefits otherwise payable to me. I understand that insurance may pay less than the actual bill for services, and that I am responsible for payment in full.

The information given on this page is accurate.

Signature_____

Date _____

REGISTRATION