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 Name & Clinic _____ 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 _____