CENTRAL PARK DENTISTRY
PERSONAL INFORMATION

Last Name First Middle

☐ Single
☐ Married
☐ Widow

Date of Birth Age

Street Address

Home Phone Work Phone

City State Zip

Social Security Number Cell Phone

Mailing address (if different from above)

Previous dentist Last visit

Person responsible for acct. Relationship Date of Birth

Employer Occupation

In case of Emerg. Contact - Name and Number

Dental Insurance Information:

Employer _____

Insurance Company Name _____

Social Security Number of Employee _____

Employee Name _____

Employee Date of Birth _____

Referred by

E-mail address

Consent for Treatment:

I hereby grant authority to Dr. Lala, Dr. Hansen, Dr. Thackery, Dr. Kolker and/or Dr. Brayton to administer any treatment; and to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of me. I understand that I will be consulted before any treatment is rendered.

(Patient or Parent of Minor Date

Our Office Policy:

To enable us to establish the best relationship possible with our patients from the very beginning and to avoid misunderstandings in the future, we have established certain office policies. Please read these pollicies and sign below signifying you have read and understand our policies.

Each patient we treat is entitled to, and will receive, a thorough and careful examination. We are dedicated to the principle of doing our best in treating all patients with the highest quality therapy possible.

It is our office policy that **24 Hours Notice must be given** if you are forced to cancel an appointment. We do not charge for "broken appointments" (no-shows and last minute cancellations.) However, after two broken appointments, we will give your file an "inactive status" and special arrangements must be made to reactivate it. Our purpose in establishing this policy is to avoid making patients wait long periods of time for an appointment. If we are given proper notice of a cancellation, it enables other patients who are waiting for treatment to be called.

Parents need not accompany their children to the treatment room. Children are usually more cooperative when their parent is not in the same room. We will examine your child and determine what he/she needs and then the doctor will discuss this with you before treatment begins.

Signature – Patient or Parent of Minor

Payment Policy:

It is customary to pay for dental services in full when treatment is rendered. We accept cash, check, Visa, and MasterCard. We do file dental insurance, but any deductibles and co-insurance are due at the time services are rendered. If at any time a financial arrangement need to be discussed, we ask that you contact our office coordinator prior to the appointment.

Signature, Patient or Parent of Minor

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