WELCOME TO NIKODEM DENTAL CARE

In order to help us serve your dental health properly, would you please be kind enough to answer the following questions.

PATIENT INFORMATION (CONFIDENTIAL)

Name_____ Date_____

Address _____ City _____ State ____ Zip _____

Home Phone_____ Cell Phone _____

Email Address _____

SS# _____ Birth Date _____

Check Appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you? _____

Consent: I authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all treatment, medication, and therapy, that may be indicated with Patient and further authorize and consent Doctor to choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If overdue, I understand cost of collection and attorney's fees will be applied.

Signature _____ Date _____

APPOINTMENT CANCELLATIONS

Except for emergencies, this office provides health care by appointment only. Please remember this time is reserved specifically for you. If you must change an appointment, we request a 24 hours notice of cancellation. A minimum charge will be made for missed or cancelled appointments without sufficient prior notice.

Please fill out the back portion of this form.