LAWSON
Family Dentistry

Welcome to our practice!

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

About You

Today's Date _____ Birth Date _____ Sex _____ ___Mr. ___Ms. ___Mrs. ___Dr.

Last Name _____ First Name _____ MI ____ Preferred _____

Parent/Responsible Party_____ Patient Social Security_____ Marital Status _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Ext _____ Driver's License _____

Where/When are the best times to reach you? _____ Email Address _____

Other family members seen by us? _____ How did you hear about our practice? _____

Employer _____ How long there? _____ Occupation _____

Address _____ City _____ State _____ Zip _____

In Case of Emergency

Contact Name _____ Relation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

SPOUSE INFORMATION

His/Her Name _____ Birth Date _____ Social Security _____

Employer _____ Work Phone _____ Ext. _____ Driver's License _____

Cell Phone _____

Consent For Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis, which may be used in publications, promotions or for other educational purposes. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed on. I agree to the use of anesthetics, sedatives and medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I may ask at any time for an explanation of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements have been made. I understand that any payment not received by agreed upon dates are subject to a l% (12%APR) Late Charge. I understand that if financing is requested, a credit history check will be made.

Patient Signature _____ Date _____ Witness _____

Parent/Responsible Party Signature _____ Relationship to Patient _____