ALTITUDE DENTAL

FAMILY DENTISTRY | PROSTHODONTICS | DENTAL IMPLANTS | COSMETIC DENTISTRY

Information Update

Our team looks forward to bringing you into our family of patients. Please help us meet all your dental needs by completing this form. If you have any questions or need assistance, please ask us – we will be happy to help.

Please complete the following confidential information:

Dr./Mr./Mrs./Ms./Miss Name: _____ Date of Birth: _____

SS#: _____ Employer: _____ Preferred Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

How did you hear about us? _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Note: Please present your driver's license for us to photocopy and keep within your file. Thank you.

Driver's License State: _____ Number: _____

Consent for Treatment

1. I hereby authorize Dr. Rolfes or designated staff to take x-rays, study models, photographs, and any other diagnostic procedures needed for Dr. Rolfes to make a thorough diagnosis of _____'s dental needs.

(Name of Patient)

2. Upon such diagnosis, I authorize Dr. Rolfes to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication, as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for an explanation of any possible complications.

Patient: _____ Date: _____

Parent or Responsible Party Signature: _____