

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
E-Mail \_\_\_\_\_ Marital Status: S M W D  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency contact person/relationship \_\_\_\_\_ Phone \_\_\_\_\_

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***If you would like reimbursement by dental benefits, please complete the following:***

**Primary** Insurance Co. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Plan name \_\_\_\_\_ ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Name of Insured/relation \_\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

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**Secondary** Insurance Co. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Plan name \_\_\_\_\_ ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Name of Insured/relation \_\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

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\_\_\_\_\_ I have received a copy of the document entitled *Dental Materials Fact Sheet* dated May 2004.  
\_\_\_\_\_ I have received a copy of this office's *Notice of Privacy Practices*.

**CONSENT:**

1. I authorize Dr. Peterson and his representatives to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate to make a thorough diagnosis.
2. I authorize Dr. Peterson to perform all recommended treatment *mutually* agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
3. I authorize the use of the x-rays, photographs, models or videotapes of my case for use in presentations or publications of the doctor.

I certify that this information is true and correct. I will notify the office of Brett T. Peterson, DDS of any changes in the above information or any changes in my health status.

Signature of Patient (Parent if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_



