Patient Information Form

Name: _____

Address: _____

City, State, Zip code: _____

Home Phone #: _____ **Work Phone #:** _____

E-mail: _____ **Birth Date:** _____

Sex: _____ **Marital Status:** _____ **Time since last dental visit?** _____

Social Security #: _____ **DL#:** _____

Insurance Info: _____

Can we leave messages for you at: Home_____ Work_____ E-mail_____ ?

What dental problems are you having now? _____

Whom may we thank for referring you to us? _____

Signature _____ **Date** _____

By signing, I authorize the office of Scott T. Gordon, D.D.S. to use all diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. I understand that a $35 fee will be assessed to my account for any appointment cancellations with less than 24 hours notice.

Signature _____ **Date** _____

I acknowledge that I have received a Notice of Privacy Practices from the office Scott T. Gordon, D.D.S.