Cordido Dental Pros

Your Healthy and Customized Smile.

NEW PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/_____
Last First Middle

Address:_____ City: _____ State:_____ Zip_____

Daytime Phone: ( )_____ Evening Phone: ( )_____

Can a voice mail be left on your phone regarding appointment reminders? Yes_____ No_____

Can a text message be sent to your phone regarding appointment reminders? Yes_____ No_____

Parent/Guardian (if patient is under 18 years old) Name:_____

Phone: ( )_____ Email Address: _____

Relationship to patient:_____

Emergency Contact:

Name: _____ Phone: ( )_____

Relationship to patient:_____

Office Financial Policy:

Cordido Dental Pros, PLLC is out of network with insurance and does not take Medicare or Medicaid. I understand that treatment fees must be paid in full before final delivery.

Patient Signature:_____ Date:_____

Media consent:

I give Cordido Dental Pros, PLLC my consent to take and use photographs (that may include full face) for use in planning clinical treatment, for coordination of treatment with other specialists involved in treatment, and for educational purposes (teaching and lecturing).

Patient Signature:_____ Date:_____