Cordido Dental Pros

Your Healthy and Customized Smile.

NEW PATIENT INFORMATION

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

Address:_____ Apt:_____ City: _____ State:_____ Zip_____

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

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

Name:_____ Phone: ( )_____

Email Address: _____Relationship to patient:_____

Emergency Contact:

Name: _____ Phone: ( )_____

Relationship to patient:_____

Emergency Contact:

Name: _____ Phone: ( )_____

Relationship to patient:_____

Consent to share Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL AND FINANCIAL INFORMATION WITH ANOTHER PERSON OR ENTITY?

____NO ____YES, MEDICAL INFORMATION ONLY

____YES, FINANCIAL INFORMATION ONLY ____YES, MEDICAL AND FINANCIAL INFORMATION

If yes, please provide their name, relationship, and phone number.

Name:_____Relationship:_____Phone number:_____
Name:_____Relationship:_____Phone number:_____
Name:_____Relationship:_____Phone number:_____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE/VOICEMAIL?

____YES ____NO If yes, phone number(s):_____

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.

Media consent:

I give Cordido Dental Pros, PLLC my consent to use photographs (that may include full face) for educational purposes (teaching and lecturing).

Signature: _____ Date: _____

If other than the patient, indicate relationship: parent or legal guardian _____