BRONSON
FAMILY DENTISTRY

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PATIENT INFORMATION FORM

Patient Last Name:	Patient First Name:	Middle Initial:
Patient Street Address:		Apt:
City:	State:	Zip Code:
Date of Birth:	Telephone Number:	
Email Address:		
Has any member of your family been treated by our office?		
Whom may we thank for referring you to our practice?		

FAMILY INFORMATION

Last Name:	First Name:	Middle Initial:
Patient Street Address:		Apt:
City:	State:	Zip Code:
Date of Birth:	Telephone Number:	
Email Address:		
Relationship to Patient:		

Last Name:	First Name:	Middle Initial:
Patient Street Address:		Apt:
City:	State:	Zip Code:
Date of Birth:	Telephone Number:	
Email Address:		
Relationship to Patient:		

Emergency Contact Information

Name:	Telephone Number:

Authorization: I hereby authorize Bronson Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as maybe necessary for proper dental care. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical history are correct to the best of my knowledge.

Signature:	Date:

PAYMENT IS EXPECTED IN FULL AT EACH APPOINTMENT