

Maureen M. Holley, DMD
Restorative and Cosmetic Dentistry

Welcome to our office!

Our team looks forward to bringing you into our family of patients. Please help us meet all your dental needs by completing this form. If you have any questions or need assistance, please ask us – we will be happy to help.

CONFIDENTIAL PATIENT INFORMATION

Date: _____
Patient Name: _____ SS#: _____ D/O/B: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Cell Phone Numbers: _____
Occupation: _____ Employed By: _____ Work Phone: _____

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name: _____ SS#: _____ D/O/B: _____
Address: _____ City: _____ State: ___ Zip: _____
Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____
Occupation: _____ Employed By: _____ Work Phone: _____
Insurance Name: _____ Policy #: _____ Group#: _____

CONSENT FOR TREATMENT

- 1) I hereby authorize Dr. Holley or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Holley to make a thorough diagnosis of my dental needs.
- 2) Upon such diagnosis, I authorize Dr. Holley to perform all recommended treatment mutually agreed upon by me and to employ such assistance as require to provide proper care.
- 3) I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient/Responsible Party Signature _____ Date: _____