



Advanced Dentures & Implants

PATIENT INFORMATION

Patient name: _____ Preferred name: _____
Birth date _____ If minor , Parent/ Guardian name _____
Home phone _____ Cell phone _____ Work phone _____
Mailing address _____
City _____ State _____ Zip _____
Email Address _____
Employer _____ Occupation _____
Emergency Contact _____ Phone number _____
Spouse's name _____ Spouse's number _____
Whom may we thank for referring you to our office ? _____

We ask for at least 24 hour notice if you need to change your appointment time. This gives us the chance to schedule the chance to schedule another patient in your place. We do charge a \$50-/ per hour fee for patients who do not show up for their scheduled appointment and for patients who fail to give us sufficient notice that they have a conflict.

Initial _____

There will be a nominal fee of \$20 forwarding x-rays to another office.

Initial _____

We cannot call in any prescriptions to pharmacy for patients that have not been seen in the last three months.

Initial _____

Patient that aren't seen for routine check ups at least once a year will be inactivated/dismissal from our office.

Initial _____

Patient's Signature

Date

Sony Markose DDS , MSD

Date