Steven C Greenman DDS

Advanced Cosmetic, Implant and Sedation Dentistry
Snoring and Sleep Apnea

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

FIRST NAME_____

LAST NAME_____

E-MAIL ADDRESS_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

OCCUPATION_____

EMPLOYERS NAME_____

WORK PHONE_____

EMERGENCY CONTACT NAME _____

EMERGENCY CONTACT PHONE NUMBER _____

Have you been told that you need to take medication before any dental treatment?

Are you allergic to latex or medication?

Do you have any heart problems or artificial joints?

Do you have any infectious diseases that could affect anyone caring for your dental health?

Are you currently taking any medications?
If yes please list medications: _____

YOU WERE REFERRED TO US BY_____

PLEASE LET US KNOW IF YOU HAVE A DENTAL PLAN THAT YOU WOULD LIKE US TO BILL FOR YOU.

I CONSENT FOR TREATMENT AND AGREEMENT TO ASSUME FINANCIAL RESPONSIBILITY.

I UNDERSTAND THAT A 1.5% PER MONTH FINANCE CHARGE MAY BE APPLIED TO UNPAID BALANCES.

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PATIENT SIGNATURE DATE