PATIENT INFORMATION

First Name: ____

Last Name: ____

Date of Birth: _______________ Male: ___ Female: ___

Cell #: _______________ Home #: ________________ Work #: ________________

Address: ____

Employer: ____

State ID/Driver's License #: _______________________ SS#: ________________________

To the best of my knowledge, I have answered every question completely and accurately.
I will inform Dr. Mehdizadeh of any change in my personal information.

Patient signature (or authorized guardian):

If authorized guardian, relationship: Date:

e-mail: ____

I authorize the floss staff to e-mail me regarding appointments, treatment planning and x-rays, treatment updates, diagnostic results, and my account status.

Patient signature (or authorized guardian):

If authorized guardian, relationship: Date: