Murad Gharibian, D.D.S. Inc.
DG Dental

Thank You For Choosing Our Practice

Patient Information Form

PATIENT INFORMATION		
Last Name	First	M.I.
Address		
City	State	ZIP
Social Security No.	E-Mail Address	
Home Phone No.	Work or Cell Phone No.	
Sex: M F	Birth Date (mm/dd/yy)	
Spouse	Employer	
Relationship to Patient		

EMERGENCY CONTACT		
Name		
Address		
Home Phone No.	Work Phone No.	
Whom May We Thank For Referring You?	Tel. No.	

PRIMARY DENTAL INSURANCE		
Insurance Company		Group No.
Insured's Name		Social Security No.
Birth Date	Relationship To Patient	
Address (if different)		

SECONDARY DENTAL INSURANCE		
Insurance Company		Group No.
Insured's Name		Social Security No.
Birth Date	Relationship to Patient	
Address (if different)		

PERSON FINANCIALLY RESPONSIBLE		
Name		Home Phone No.
Address		
Birth Date	Social Security No.	

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize all recommended treatment mutually agreed upon by me and the doctor as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____**Date**_____**Witness**_____

Parent or Guardian's Signature_____ **Relationship to Patient**_____