



Sharen C. Strong, D.M.D.

General Dentistry
Personalized and Comfortable Dental Care
155 Delaware Ave., Bandon, OR 97411
541-347-5555 Fax 541-347-5145

WELCOME TO OUR PRACTICE!

PLEASE FILL OUT THE INFORMATION BELOW:

Patient Name _____

Age _____ Male Female

Child: Parent's Name _____

Date of Birth _____

How do you wish to be addressed? _____

Social Security No _____

Single Married Minor

PRIMARY INSURANCE

Address _____

Insurance Company _____

City _____ State _____ Zip _____

Policy No _____

Business Address _____

SECONDARY INSURANCE

Phone: Res _____ Business _____

Insurance Company _____

Cell _____ Fax _____

Policy No _____

Employed by _____

AUTHORIZATION/CONSENT TO TREATMENT

Present Position _____

I hereby authorize Dr. Sharen C. Strong DMD or her staff to perform dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition, including dental x-rays and administering of local anaesthetics. I understand that any dental treatment involves certain risks. If I wish to have a more detailed explanation of the diagnosis, treatment risks or alternatives to treatment, I will ask for such.

How long held _____

I consent to Dr. Strong's use and disclosure of my records to carry out treatment and to obtain payment.

Spouse Name _____

FINANCIAL RESPONSIBILITY

Employed by _____

I authorize payment directly to Dr. Strong of insurance benefits otherwise payable to me. I understand that insurance may pay less than the actual bill for services, and that I am responsible for payment in full.

Who is responsible for this account _____

The information given on this page is accurate.

Drivers License No _____

Signature _____

Method of payment Insurance Cash/Check Credit card

Date _____

Purpose of visit today _____

REGISTRATION

Other family members at this Practice _____

How did you hear about our office? _____

In case of emergency call _____

Phone _____ Relation _____