CARROLLTON
Advanced Family Dentistry

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*