CUSTOM DENTAL
GENERAL & COSMETIC FAMILY DENTISTRY
3409 GALLOWAY DRIVE UNIT 402
BAKERSFIELD, CA 93312
661-387-6577

Patient Information Form

Email Address _____

Patient Name: First _____ MI _____ Last _____

Address: Street _____City _____ State _____ Zip _____

Phone: Home _____ Work _____Mobile _____

Social Security Number _____ Date of Birth _____

Driver's License # _____ State _____

Employed By _____ Occupation _____ Phone _____

Address: Street _____City _____ State _____ Zip _____

Sex ☐Male ☐Female Please mark appropriate status: ☐Minor ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____Home Phone _____ Mobile Phone _____

Name of Responsible Party: _____

Date of Birth _____ Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other_____

Address: _____City _____ State _____ Zip _____

Phone: Home _____ Work _____Mobile _____

Employer _____ Phone _____

Employer Address _____City _____ State _____ Zip _____

Primary Dental Plan Name _____

Name of Insured _____ Date of Birth _____

ID Number _____ Group Number _____Group Name _____

Patient Relationship to Insured _____

Secondary Dental Plan Name _____

Name of Insured _____ Date of Birth _____

ID Number _____ Group Number _____Group Name _____

Patient Relationship to Insured _____

To the best of my knowledge, the above information is correct. I will inform my dentist of any changes to my contact and/or insurance information.

_____ _____

Signature Date

INFORMED CONSENT FOR RADIOGRAPHS

Radiographic X-Rays _____Intial

I am to receive a full mouth set of x-rays every three to five years to provide diagnostic information and documentation for the dentition and surrounding tissues. I will receive periodic examination x-rays, every six months or as assessed by the doctor, for the correct and accurate diagnosis of the dentition. All reasonable precautions will be taken to minimize the exposure to radiation.