New Patient information

Name: (First, Last):

_____

Date of Birth: _____/_____/_____

Height: _____

Weight: _____

Age:_____

Male_____ Female_____

Adress:_____

_____

City: _____ State:_____

Zip_____

Daytime Phone: ( )_____

Evening Phone: ( )_____

Can a voice mail be left on your phone regarding appointment reminders?

Yes_____ No_____

Email: _____

Do you give consent to receive information via email that concerns your treatment?

Yes_____ No_____

Parent/Guardian (if patient is under 18 years old)

Name:_____

Phone: ( )_____

Email Address: _____

Relationship to patient:_____

Emergency Contact:

Name: _____

Phone: ( )_____

Relationship to patient:_____

Office Financial Policy:
Advanced Prosthetic Restorations is out of network with insurance and does not take Medicare or Medicaid. I understand that treatment fees must be paid in full before final delivery.

Patient Signature:_____ Date:_____

Media consent:
I give Suzanne Verma of Advanced Prosthetic Restorations my consent to take and use photographs (that may include full face) for use in planning clinical treatment, for coordination of treatment with other specialists involved in treatment, and for educational purposes (teaching and lecturing).

Patient Signature:_____ Date:_____