Welcome to Aesthetic Dentistry of Lake Oswego

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Guest Registration

Last Name:_____First:_____M.I.:_____

Preferred Name:_____Birth Date:_____Male/Female:_____

Home Phone:_____Cell:_____Work:_____

Address:_____City: _____St.:_____Zip:_____

Email:_____ SS#:_____

Responsible Party: _____Phone#:_____

Address:_____City: _____ St.: _____Zip:_____

SS#:_____ Birth Date:_____ Relationship to Patient:_____

Employer:_____ Insurance Company:_____ Group #:_____

Person to contact for Emergency:_____Phone#:_____

How did you hear about us?_____

Consent for Treatment

* I hereby authorize Dr. Bowden or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor so that he can make a thorough diagnosis of my dental needs and that these records may be used for diagnostic purposes, educational purposes, and research. I hereby give my consent for my records to be used for these purposes.

* Upon such diagnosis, I authorize Dr. Bowden to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

* I agree to the use of anesthetics, sedatives, and medications as necessary. I fully understand that using anesthetic agents, medications, dental materials, and treatment procedures embodies certain risks. I understand that I can ask for a complete recital of any complications.

* All health questions are answered to the best of my knowledge. I will notify Dr. Bowden of any change in my health, and my health provider or agency may release information to you.

* I acknowledge receipt of the Notice of Privacy Practices.

* I agree to be responsible for payment of all services at the time of service. In the event payment is not received as agreed, I understand that a 1.5% late charge per month may be added to my account.

*Patient/Parent Signature:*_____*Date:*_____