General Examination/Treatment Consent Form

(This update must be completed and signed <u>every</u> <u>visit</u> along with medical history)

Patient Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Cell or Home

E-Mail: _____

Social Security: _____

How did you hear about us? ☐ TV ☐ Radio ☐ Insurance ☐ Passing By (sign)
☐ Internet/web-site ☐ Health-fair ☐ Mail
☐ Family/Friend _____
☐ Other _____

By signing this form, you consent to the examination and/or previous agreed diagnosis treatment to be performed here at Ideal Smiles by our dentist, hygienist and assistants.

_____

Patient or Guardian Date

_____

Witness Date