Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us we will be happy to help.

Welcome

PDO PERSONAL DENTAL OFFICE

6222 Wilshire Blvd. Suite 103
Los Angeles, CA. 90048
(323) 933-4444

Has any member of your family been a patient of our office? ☐ YES ☐ NO

PATIENT INFORMATION

P.T.L. _____

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: ( ) _____-_____ Work: ( ) _____-_____ Ext: _____ Cell Phone ( ) _____-_____

D.O.B: _____/_____/_____ Age _____ Sex: ☐ Male ☐ Female S.S# _____-_____-_____

E-Mail Address: _____

Employer: _____
(Name of Company) (Address) (Phone)

MARITAL STATUS

☐ Minor ☐ Single ☐ Married Name of Spouse: _____

Who should we contact in an emergency: _____ Phone: _____

SUBSCRIBER/RESPONSIBLE PERSON

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: ( ) _____-_____ Work Phone ( ) _____-_____

SS#: _____-_____-_____ D.O.B: _____/_____/_____

Employer: _____ Phone: ( ) _____ -_____
(Name Of Company) (Address)

Whom should we thank for referring you to our office: _____

METHOD OF PAYMENT

Full payment for the dental treatment provided is expected at the time of service. For your convenience, we accept cash, checks, and all major credit cards. For our patients who need extended payments, we offer ***CARE CREDIT/CITI FINANCIAL***

A note about keeping your appointments.

We reserve time for you. ***There is a charge for broken appointments.*** *Failure to notify the office less than 24 hours constitutes a broken appointment. (This applies only to weekdays)*

TRANSFER CANCELLATION PROCEDURE

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIAL FACT SHEET (DMFS)

I, _____, acknowledge I have received from **Personal Dental Office** a copy of the Dental Material Fact Sheet dated October 17, 2001.

_____

Patient Legal Name

_____ _____

Patient Signature (Legal Guardian) **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's **Notice of Privacy Practices.**

I, _____ herby grant authority to _____, my _____, to obtain information on all files necessary pertaining to any and claims under my responsibility from Personal Dental Office and its affiliates. This authorization is effective immediately and can be revoked in writing at any time. A photocopy of this authorization is as valid as the original. I further authorize the above named person to schedule appointments in my absence.

Thank you,

Patient Name: _____

Patient Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt or our Notice of Privacy Practices, but acknowledgement could not be obtain because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____