Trenton LeBaron, D.M.D.

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Keizer, OR 97303

503-393-9106
www.keizersmilecenter.com

Patient Information

Patient Name: _____

Preferred Name: _____ Date of Birth: _____ Sex: [ ] Male [ ] Female

Address: _____City:_____State:_____ Zip:_____

Preferred phone: _____ [ ] Mobile [ ] Home [ ] Work [ ] Other

E-mail: _____

How would you like to receive appointment reminders? [ ] Call [ ] Text [ ] E-mail [ ] Postcard

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

May we share protected health information with this person? [ ] yes [ ] no

Financial Responsibility

Name of Responsible Party or Policy Subscriber: _____

Date of Birth: _____ Relation to Patient: _____

Address: _____City:_____State:_____ Zip:_____

Phone Number: _____ E-mail: _____

Employer: _____ Occupation: _____

Insurance Carrier: _____ Policy Name: _____

SSN or Subscriber ID: _____Group Number: _____

Initial Contact

Reason for today's visit _____ Date of last dental visit_____

Last dentist visited_____ Date of last dental X-rays _____

Address of last dentist _____ Phone Number_____

How did you hear about our office? _____

To the best of my knowledge, the information provided on this form has been accurately answered. I give consent to receive dental treatment deemed necessary by the providers at Keizer Smile Center. These procedures include, but are not limited to: X-ray radiographs, examination, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings or crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of oral anesthetics. I understand the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked in writing.

_____ _____

Patient Signature **Date**