PAPPERT AND KIRK
FAMILY DENTISTRY

Date: _____

NEW PATIENT / UPDATE INFORMATION

Name _____ Male/Female _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Age _____

Home # ( ) _____ Business # ( ) _____ Ext. _____

Mobile # ( ) _____ E-Mail _____

Employer's Name _____ Position _____

Name of Spouse _____ Social Security # _____

Address (If different from above) _____ Spouse DOB _____

Spouse Employed by _____

Spouse Business Phone # ( ) _____ Ext. _____ Spouse Position _____

Spouse Mobile # ( ) _____ E-Mail _____

Children Names & Ages _____

How did you hear about us? _____

Name, Address & Phone # of **local** emergency contact. _____

_____

Chief Dental Concern _____

PERMIT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of dental and/or oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's Signature) _____ Date: _____

DENTAL INSURANCE INFORMATION

Name of Company or Companies _____

_____

(We will need a photocopy of card (s):).

I understand that as a service (to me) Drs. Pappert & Kirk Family Dentistry will assist me in processing my insurance claims. However, I am responsible for all fees in their entirety at time treatment is performed.

Patient's (Parent's Signature) _____ Date: _____

Graham Office Park Building B-102 • 4525 Park Road • Charlotte, NC 28209
P: 704-523-4515 • **F:** 704-523-4006
Email: greatsmiles@dentalcarecharlotte.com • www.dentalcarecharlotte.com

I understand my complete medical history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.

Signature of Patient or Guardian	Date
Signature of Patient or Guardian	Date
Signature of Patient or Guardian	Date
Signature of Patient or Guardian	Date
Signature of Patient or Guardian	Date
Signature of Patient or Guardian	Date

Note: New Patient Information Sheet is requested every two years. Updated signatures are requested a minimum of every 6 months. Your assistance is appreciated.