# CONFIDENTIAL INFORMATION

<table>
<tr><td colspan="4">Patient’s Name Last First Middle</td><td>Date of Birth</td><td>Sex</td></tr>
<tr><td colspan="4">Patient’s Address City Province Postal Code</td><td colspan="2">Home Phone</td></tr>
<tr><td>Marital Status<br>❑M ❑S ❑D ❑W<br>❑Under 18 ❑Common Law</td><td>Occupation</td><td>Work Phone</td><td colspan="3">Parent/Legal Guardian (if applicable)</td></tr>
<tr><td colspan="2">Email Address</td><td colspan="4">Spouse’s Name & Contact Number</td></tr>
<tr><td colspan="6">Emergency Contact Information<br>Name Relationship Work# Other#</td></tr>
<tr><td colspan="6">General Dentist City Contact #</td></tr>
<tr><td colspan="6">Family Doctor City Contact #</td></tr>
<tr><td colspan="6">Pharmacy City Contact #</td></tr>
<tr><td colspan="6">Who Can We Thank for Referring You to Our Office</td></tr>
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## Assignment & Release:

In consideration of the services rendered to me by his dental office I am obligated to pay said office in accordance to its credit terms and policy.

I consent to the making of videotapes, photographs, and X-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature ______________________________ Date ______________