DR. BORTOLUSSI & ASSOCIATE
Specialists in Dental Prosthodontics

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Patient Information					
Last Name:		First Name:		Middle:	
D.O.B (D/M/Y):		Sex:			
Address:					
	(Street Number, Name, City, Province, Postal Code)				
Telephone (H):		Telephone (M):			
Occupation:		Telephone (W):			
Email:					
If Applicable, Legal Guardian and Relationship:					

Emergency Contact					
Name:		Relationship:		Contact #	

Additional Information					
General Dentist:		City:		Contact #:	
General Physician:		City:		Contact #:	
Who can we Thank for Referring You to Our Office:					

Pharmacy Information			
Pharmacy Name:		Contact #:	

Assignment & Release

In consideration of the services rendered to me by the dental office I am obligated to pay said office in accordance to it credit terms and policy.
I consent to the making of videotapes, photographs, radiographs before, during and after treatment, and to the use of the 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.

I authorize release of my dental records to Dr. Bortolussi for continuation of care should said office need access to these records for this purpose. Please release all records to office contact information above.

Signature:		Date (D/M/Y):	

Note: This Authorization must contain the original signature of:
A) The patient
B) The parent or legal guardian if the patient is under 16 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent