

# Dental Designs

OXNARD AESTHETIC DENTISTRY

**Welcome to our office!** We sincerely appreciate your choosing us as your dental office and look forward to your becoming a part of our family of patients. We understand that you may be feeling a bit apprehensive about today's visit but don't worry, this is a very natural feeling. We know that there are many thoughts going through your mind. In order for us to put you at ease and to get to know you better, **it is very important for you to answer the following questions accurately.** Please take your time. Thank you for your help.

**Name:** \_\_\_\_\_  
(Last) (First) (Middle)

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_  
(Home) (Business)

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** (M)(F) **Ht.:** \_\_\_\_\_ **Wt.:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Marital Status:**(Single)(Married)(Divorced)(Widowed) **Spouse's Name:** \_\_\_\_\_

**Dental Insurance Co.:** \_\_\_\_\_ **Soc. Sec. No.:** \_\_\_\_\_

**What is the reason for today's visit?** \_\_\_\_\_

**Most Convenient Appointment Time:** \_\_\_\_\_ **Day of the Week:** \_\_\_\_\_

**Who can we thank for REFERRING YOU:** \_\_\_\_\_

I consent to whatever dental procedures and anesthetics that are considered necessary for the proposed treatment. I also permit the release of any information to or from my physician as may be required. I agree to assume full financial responsibility for all the dental treatment rendered.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Signature of Dentist/Witness

Date / /

\_\_\_\_\_ I acknowledge that I have received a copy of the Dental Materials fact sheet.

\_\_\_\_\_ I acknowledge that I have received a copy of the Notice of Privacy Practices.

**Dental Practice of  
Marie E.C.S. Alejandrino-Buell, D.M.D., Inc.**