DECK DENTISTRY | Patient Registration and Consent Form

Name _____ _____ _____ Date of Birth ___ / ___ / ___
Surname First Name(s) Your Preference D M Y

Parent or Legal Guardian (if under 18 yrs) _____

Gender _____ Marital Status _____ Spouse's Name _____
M / F Married / Single

Telephone(s) _____ _____ _____
Home Work Mobile

Address _____
Complete mailing address, including PO Box or "911" number and Postal Code.

Email Address _____

Previous Dentist _____ Telephone _____

Family Doctor _____ Telephone _____

Medical Specialist _____ Telephone _____
Dr.'s Name and Specialty

Emergency Contact _____ Telephone _____
Relationship: ☐Spouse ☐Parent ☐Guardian ☐ Friend

Whom can we thank for referring you to us? _____

Who is responsible for your account? ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Name _____ Telephone _____

May we contact you at work? ☐ Yes ☐ No

Your Employer _____ Telephone _____

Your Spouse's Employer _____ Telephone _____

Do you have Dental Insurance? ☐ Yes ☐ No

I have reviewed the information that explains how your office will use my personal information. I know that your office has a Privacy Code, and that I can ask to see the Code at any time. I agree that Deck Health Services Inc., can collect, use and disclose personal information about me as set out in their office's privacy policies.

Drs. Gregory Deck and Carolyn Deck provide the professional services rendered at our office. Deck Health Services Inc., an independent provider of technical health care services owned by Gregory Deck and Carolyn Deck, provides technical health care services, such as x-ray services, surgical assistance services and educational services.

Signature _____ Date _____

Witness Signature _____ Date _____