Kurt C. Rolf, DDS

PATIENT REGISTRATION

Patient Information (please print) Date _____

Name _____ Preferred Name _____ ○ Male ○ Female

Address _____ Home Phone _____

City/State/Zip _____ Work Phone _____

Email _____ Cell Phone _____

Date of Birth _____ Marital Status ○ Single ○ Married ○ Widowed ○ Divorced

Place of Employment _____ Soc Sec # _____

Whom may we thank for referring you to our office? _____

Responsible Party

Name _____ Employer _____

Soc Sec # _____ Date of Birth _____

Address _____ Home Phone _____

City/State/Zip _____ Work Phone _____

Person to Contact in Case of Emergency

Name _____ Relationship _____

Address _____ Home Phone _____

City/State/Zip _____ Work Phone _____

Authorization

I hereby authorize Kurt C. Rolf DDS PC to administer such medications and perform such diagnostic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party and/or other health professionals. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are correct to the best of my knowledge.

SIGNATURE _____ DATE _____