GREGORY T. NASSIF, D.D.S.

2335 Church St. Suite D
Zachary LA 70791
225-654-6814

WELCOME

Thank you for selecting our dental team! We will always offer you the most up to date dental care available today. To help us meet your dental needs, please fill out these for us. Thank you for your cooperation.

Personal Information

Name_____ Male Female Single Married

Address_____ City/State/Zip_____

Social Sec#_____ DOB: (M/D/YR) ___/____/_____

Name of spouse_____

Wish to be called_____ Occupation_____ Employer_____

Who may we thank for referring you to our office?

_____

Responsible Party

Name _____ Relation to patient_____

Birth Date_____ Drivers License # _____ Social Sec. #_____

IT IS UNDERSTOOD THAT DR. NASSIF OR HIS STAFF WILL NOT TREAT A PERSON UNDER THE AGE OF 18 WITH OUT THE INFORMED CONSENT OF THE PARENT OR GUARDIAN.

Signature of Parent/

Guardian_____

How may we contact you?

Home Phone _____ Work Phone _____ Ext._____Cellular Phone_____

Email_____ Where do you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time_____ Days M T W TH F

Consent for treatment

1. I hereby authorize Dr. Nassif or his delegated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Nassif to make a thorough diagnosis of

   _____'s dental needs.
   Patient name

2. Upon such diagnosis, I authorize Dr. Nassif to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent and authorize Dr. Nassif or his designated staff to use and disclose any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I further understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that payment is due at the time of service unless other arrangements have been made in advance. If required, I also understand a check of my credit history may be made.

Patient's signature_____ date_____
Witness_____

Parent/responsible party's signature_____
Relationship to Patient _____