ELITE
DENTAL & AESTHETICS

Welcome to our practice. We look forward to providing you with excellent care in dentistry and facial aesthetics. Please fill out the following information so we may best serve you.

Dr. Carolina Borgenicht • Dr. Santiago Lopez • Dr. Jack Behn

PATIENT INFORMATION

TODAY'S DATE: _____ /_____/_____

FIRST NAME: _____ LAST NAME:_____

HOME ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____ COUNTRY:_____

AGE:_____ DATE OF BIRTH (mm/dd/yy): _____ /_____/_____ MARITAL STATUS: ☐ Single ☐ Married

SEX: ☐ M ☐ F EMAIL ADDRESS (For our office use only): _____

HOME PH #: (_____)_____ CELL PH #: (_____)_____ WORK PH #: (_____)_____

EMPLOYER: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT US? REFERRAL: Who may we thank for recommending us? _____

ONLINE: ☐ google ☐ facebook ☐ other online source: _____

EVENT: ☐ seminar ☐ bridal show ☐ spa event ☐ school event

MAILING: ☐ magazine ☐ postcard

EMERGENCY CONTACT

NAME OF PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ HOME PH #: (_____)_____ CELL PH #: (_____)_____

PLEASE TELL US ABOUT YOURSELF

Reason for today's visit: _____

Have you had Botox® treatment in the past? ☐ Yes ☐ No If yes, how long ago? _____

Have you had facial fillers (such as Juvederm®, Restylane, Perlane, Voluma™) in the past? ☐ Yes ☐ No

If yes, how long ago? _____

Do you clench your teeth? ☐ Yes ☐ No

Do you have TMJ pain? ☐ Yes ☐ No

Do you get frequent headaches? ☐ Yes ☐ No

Date of last dental cleaning: _____ Date of last dental x-rays: _____

I, the undersigned (patient or legally responsible party), authorize treatment to be rendered by the doctor and his/her staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I acknowledge that all the information contained herein is true and correct and give my permission to verify any of the information provided. I, the undersigned (patient or legally responsible party), have reviewed the HIPAA Privacy Policy Notice available in the office of Elite Dental & Aesthetics.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: _____/_____/_____