Arthur Silva, DD
Dr. Mark Dundas, DDS
15416 N. 99th Avenue, Sun City, AZ 85351
Phone: 623.875.7917 / Fax: 623.875.6010

Today's Date_____ Date of Birth __/___/ _____Age_____

Patient Last Name_____ First Name_____ MI___

Patient Preferred Name_____Occupation_____

Address_____

____

City _____ State_____ Zip_____

Cell Phone_____ Work _____ Other_____

(Where we may leave a confidential message)

Please Circle: Male Female **Please Circle:** Single Married Widowed

Dental Insurance

_____

Name of Employer

_____

Spouse's Name

_____

Physician_____ Phone _____

Date of Last Physical Exam

_____

Emergency Contact _____ Relationship _____

Last Dental Exam _____ Dental Cleaning

_____

I acknowledge that the information provided is accurate to the best of my knowledge. I authorize DDL Dental and/or trained staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make thorough diagnosis of my dental needs. I also authorize DDL Dental and Staff to perform any form of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. We reserve the right to charge interest on any balances over 60 days old at the rate of 18%. **I further understand that in the event of non-payment, I agree to pay any interest, reasonable attorney fees and collection cost in addition to other relief afforded to enforce collections. I hereby acknowledge that the above information is true and correct and I accept the office policies stated above.**

_____

_____

Signature of Patient/Parent or Legal Guardian Date