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 PreferredName_____Occupation_____

Address_____

City _____ State_____Zip_____

Cell Phone_____ Work _____ Other_____

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 knowled ge. 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 is true and correct and I accept the office policies stated above.

_____ _____

Signature of Patient or Legal Guardian Date