Dr. Brenda Taege, DDS, LLC
Cosmetic and General Dentistry

8416 East Shea Blvd.
Scottsdale, AZ 85260
480-860-6744

ADULT INFORMATION

Date: _____

Full Name of Patient: _____

Nickname: _____ Date of Birth: _____ Age: _____

Address: _____

_____

Phone number: _____ ☐ Male ☐ Female

Social Security Number: _____ Marital Status: _____

Occupation: _____ Work Phone number: _____

Name and Address of Employer: _____

_____

_____

Who can we thank for your referral? _____

Do you have Dental Insurance? ☐ Yes ☐ No

Name and Address of Insurance Company: _____

Name of Insured Person: _____

Social Security Number of Insured Person: _____ Policy Number: _____

Insurance Group Number or Other Pertinent Information: _____

Reason for Visit: _____

_____

_____

CONSENT:
The undersigned hereby authorizes the Doctor to take X-rays, study models, take photographs, or use any other diagnostic aid deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all kinds of treatment, prescribe medication and therapy, which may be useful in the diagnosis and treatment of:
(Name of Patient) _____

I further authorize and consent that the Doctor may choose and employ assistance as she deems fit. It is also my understanding that responsibility for payment of the Dental Services provided in this office, for myself or any of my dependents is mine. Payment is due and payable at the time of those services. Furthermore, I understand that a 1 1/2% finance charge (18% annually) wi1l be added to any balance after completion of planned treatment. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient: _____ Date: _____
Parent or Responsible Party: _____
Relationship to Patient: _____