Tate C. Langdon D.D.S., PA
COSMETIC AND FAMILY DENTISTRY

Patient Information

Patient Last Name: ______________________ **First Name:** ______________ **M.I.** ______

Patient Address Line 1: ______________________

Patient Address Line 2 (Apt#, Lot#, Suite): ______________________

City: ______________________ State: ______________ Zip: ______________ / ______

Preferred Name (Nickname): ______________________

Guarantor (Person responsible for paying bill): ______________________

Whom may we thank for referring you to our office?: ______________________

Employer Name & Address: ______________________

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Home Phone: ______________________ **Work Phone:** ______________________

Mobile Phone: ______________________ **Social Security #:** ______________________

Birthday: ______________________ **Gender:** ○ **Male** ○ **Female**

Driver's License #: ______________________

Today's Date (Consent): ______________________

INSURANCE ○ Yes ○ No

Employee Name ______________________

Social Security # ______________________

Date of Birth ______________________

I understand I will be informed of all treatment recommended by Dr. Langdon and consent to all treatment performed in this office.

I will allow Dr. Langdon to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my conditions with my physician and to request medical information from him.

I understand that I am responsible for all costs which my insurance company may not pay at time of services rendered.

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient
Parent, or Guardian ______________________ Date ______________________