Elizabeth P. Gladnick, DMD
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15215 Shady Grove Rd. Suite 103
Rockville MD, 20850
301-963-0800

Patient Information

First Name: _____ Last Name: _____Middle Initial: __

Preferred Name: _____Date of Birth: ___ /____ /____ Age:___ Social Security#:_____

Sex: ☐ Male ☐ Female Check One: Child ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext. ____ Cell Phone: _____

Occupation**:** _____ E-mail Address**:** _____

Who may we thank for referring you: _____

Emergency Contact: _____ Relationship: _____Phone: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Responsible Party

Same as above ☐

First Name: _____ Last Name: _____Middle Initial: ____

Preferred Name: _____Date of Birth: ___ /____ /____ Age:___ Social Security#:_____

Sex: ☐ Male ☐ Female Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext. ____ Cell Phone: _____

Occupation**:** _____ E-mail Address**:** _____

OVER

Primary Dental Insurance Information

N/A ☐

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Insured Social Security #:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Company Name: _____

Member ID: _____ Group Number: _____

Employer Name: _____ Phone: _____

Secondary Dental Insurance Information

N/A ☐

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Insured Social Security #:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Company Name: _____

Member ID: _____ Group Number: _____

Employer Name: _____ Phone: _____

Consent for Treatment

1. I hereby authorize the dentist or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature: _____ Relationship to Patient:_____

Date: _____