(Please fill out and bring to your initial visit)

Adeline W. Yuh, D.D.S., L.L.C.

SPECIALIST IN PROSTHODONTICS
414 Chatham Square Office Park
Fredericksburg, VA 22405
(540)371-0030
fax: (540)371-1421 email: info@yuhprosthodontics.com

NAME: (Mrs. Mr. Ms. Dr.) ____
First Middle Last

SOCIAL SECURITY NO.: _____-_____-_____DATE OF BIRTH: _____/_____/_____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

PATIENT HOME ADDRESS: ____
Street City State Zip Code

PATIENT HOME PHONE: __________________ PATIENT WORK PHONE: _________________

PATIENT CELL PHONE: __________________ PATIENT EMAIL: _______________________

REFERRED BY: __________________ REASON FOR REFERRAL: ______________________

____

PATIENT EMPLOYER: __________________________ OCCUPATION: ___________________

BUSINESS ADDRESS: ____
Street City State Zip Code

PERSON RESPONSIBLE FOR ACCOUNT: ____
Name Address

DENTAL INSURANCE INFO. (Dr. Yuh is non-part):

____

____
Company Address

POLICY ID AND GROUP NUMBER: ____

POLICY SUBSCRIBER INFO: ____
Name, Date of Birth and SSN (if different from patient)

I hereby authorize Dr. Yuh or designated staff to take x-rays, photographs and any other diagnostic aids deemed appropriate by Dr. Yuh to make a thorough diagnosis of my dental needs. Upon such diagnosis I authorize Dr. Yuh to perform all recommended treatment **mutually agreed upon by me** and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

SIGNATURE: ____ DATE: __________________