ISAAC E. CUETO, DDS
GATEWAY
DENTAL CARE

Patient Name _____ Male Female

Legal Guardian Name (if patient is under 18) _____

Date of Birth _____ Social Security # _____ Married Single

Address _____ Apt # _____

City _____ State _____ Zip _____

Telephone Numbers: Home _____ Work _____ Cell _____

Email Address _____ Employer _____

Nearest relative not living with you:

Name _____ Address _____

City/State/Zip _____ Phone # _____

How did you hear about our office? Check all that apply:

Friend/Relative (name) _____

Phone book _____Mailer _____ Website _____ Drive By _____

Please tell us what services you are interested in: (circle all that apply)

Replacing silver fillings	Having a whiter smile
Oral Conscious Sedation	Tooth replacement (implants/bridge)
Smile Makeover	Straighter teeth

Please tell us of any other specific dental concerns you may have: _____

CONSENT TO PROCEED: I authorize Gateway Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility, including arrangements and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. Further, I understand that I am entering into a contractual relationship with the Gateway Dental Doctors for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare, and may result in the irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agree not to advance, directly or indirectly, any false, meritless and/or frivolous claim(s) of medical/dental malpractice against Gateway Dental Doctors. Furthermore, should a meritorious medical/dental malpractice case or case of action be initiated or pursued, I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Gateway Dental Doctors agree to the same stipulations.

_____ _____

Signature of Patient, legal guardian or agent Date

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