Please **PRINT** all information

***PATIENT NAME**:_____
First Name Last Name

❑ Male
❑ Female

***PATIENT BIRTHDATE**: _____-_____-_____

ADDRESS: _____
Street or PO Box Number

_____
City State Zip

Phone (hm):(____)____-_____ Phone (wk):(____)____-_____

REFERRING DOCTOR:_____
First Name Last Name

⇓⇓⇓ * * * If patient is under 18 years of age* * * ⇓⇓⇓

NAME OF RESPONSIBLE PERSON:_____
First Name Last Name

You have the right to read our *Notice of Privacy Practices* before you sign this form.

Your signature below signifies that you authorize ***Orange Coast Dental X-ray Lab*** to perform the imaging procedures prescribed by the doctor named above and accept full financial responsibility. You also consent to our use and disclosure of your protected health information, including the possible electronic transmission (email) of images and information to any doctor who may request them for the purpose of providing care for you or a minor child for whom you are responsible.

SIGNATURE:_____ DATE:_____

Orange Coast Dental X-ray Lab
19012 Brookhurst St. • Huntington Beach, CA. 92646 • (714) 964-6440
www.OrangeCoastDental.com • OrangeCoastDental@yahoo.com

You may complete this form in advance,

bring it to the appointment,

OR

Fax it to (714) 964-4860

OR

Scan it and email it to:

OrangeCoastDental@yahoo.com