Leah Olson, DMD

Cosmetic & Family Dentistry

1800 Cooper Point Rd SW #23
Olympia, WA 98502
P: (360)352-1330 F: (360) 357-8452
info@leaholsondmd.com
leaholsondmd.com

PATIENT INFORMATION

Patient's Name _____ Person Completing Form _____

Home Address _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ / _____ / _____ ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Nearest Relative _____ Relationship to you_____ Phone # _____

Relative's Address _____

Whom may we contact in case of an emergency _____ Phone # _____

Name of previous dentist _____

Whom may we thank for your referral? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____

Mailing Address _____

_____

Social Security # _____

Occupation _____

Years with current employer _____

Current employer _____

Employer Address _____

Name of Spouse _____

Mailing Address _____

_____

Social Security # _____

Occupation _____

Years with current employer _____

Current employer _____

_____

DENTAL INSURANCE COVERAGE ☐Yes ☐No

Primary Coverage

Subscriber _____

Subscriber Date of Birth _____

Ins Co. Name _____

Ins Co. Address _____

_____

Group # _____ Plan / Local # _____

Social Security # _____

Secondary Coverage

Subscriber _____

Subscriber Date of Birth _____

Ins Co. Name _____

Ins Co. Address _____

_____

Group # _____ Plan / Local # _____

Social Security # _____

Appointments- A charge will be applied if a scheduled appointment is not kept or cancelled without a 24hour notice.

Permission for Treatment- I hereby grant permission for Dr. Leah Olson DMD and staff to perform necessary diagnostic services, anesthesia, emergent and pertinent dental treatment. I understand the risk of complications accompany all dental procedures and that certain existing conditions may compromise the result.

Payment for Services- I agree to promptly pay all charges upon receipt of statement, unless prior credit arrangement have been agreed upon in writing. In the event legal action should be necessary to collect such charges, Dr. Leah Olson DMD will be entitled to any or all costs, including attorney's fees.

☐ I hereby grant permission for Dr. Leah Olson DMD to use any images taken for educational articles, website, and social media in a non-identifiable manner.

Signature _____ Date _____ / _____ / _____