

*Bethesda Sedation Dentistry*  
*Dr. Robert Schlossberg*  
*Dr. Deborah Klotz*

Date: \_\_\_\_\_  
D.O.B: \_\_\_\_\_  
SS #: \_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
(Cell) \_\_\_\_\_ (E-mail) \_\_\_\_\_  
Sex: F \_\_\_ M \_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Has any member of your immediate family been in this office before: \_\_\_\_\_  
Name of that person: \_\_\_\_\_  
Referred by another doctor or patient: \_\_\_\_\_  
Did you hear our radio ad? \_\_\_\_\_  
Have you visited our website: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN ABOVE)**

Name: \_\_\_\_\_ Relationship : \_\_\_\_\_ SS# : \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone (H): \_\_\_\_\_ (W): \_\_\_\_\_

**EMERGENCY NOTIFICATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and doctor and that I am responsible for all dental fees.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date