San Diego Prosthodontics

Dr. Harold Gulbransen
Dr. Scott Recksiedler

Patient Registration Form:

Today's Date_____

Name_____ Home Phone_____
Last First

Address_____ Business Phone_____
Number Street

City/St_____ Zip Code_____ Cell Phone_____

Occupation_____ Email Address_____

Date of Birth_____ Sex: M F Social Security Number_____

Name of Spouse_____

Closest Relative/ Emergency Contact_____ Phone_____

If you are completing this form for another person, what is your relationship to this person?

Who may we thank for referring you to our office?

Release for Treatment:

I authorize DR. GULBRANSEN/DR. RECKSIEDLER and/or any other agents or employees as selected by them to treat me. This treatment may require the administration of local anesthetics (EXCEPT for _____, which I am allergic to). Although these anesthetics are used for my benefit, they may occasionally cause inflammation, allergic reaction, pain, nerve damage because of anatomic variations, fainting and high and/or low blood pressure.
I also authorize DR. GULBRANSEN/DR. RECKSIEDLER to photograph me for use in educational and teaching purposes.

Signature:_____Date:_____

Print Name:_____