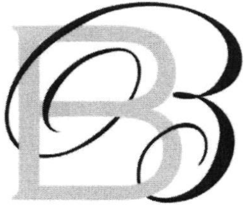

Dr Byron M Blasco DMD, Ltd

Welcome to our practice!

The dental practice of Dr. Byron M. Blasco has been part of the Las Vegas community for decades. Understanding that everyone has their own feelings about dentistry, the entire practice prides itself in treating each patient as an individual and tailoring appointments to their needs. Our goal is to provide you with the highest quality and most comprehensive care possible. To provide this standard of care, some procedures maybe required that you are unfamiliar with – if this is the case, PLEASE ask us questions.

Dr. Blasco and his team maintain their level of knowledge through attendance of numerous continuing education courses throughout the year. The practice is equipped to provide our patients with the technology required to provide the level of care we wish to have available for our patients.

The practice offers over a dozen unique services ranging from aesthetic restorations to full mouth reconstruction, Invisalign, and treatment in the areas of sleep apnea, snoring, appliances for increased athletic and technical performance, and Botox and dermal fillers for TMJ issues and facial esthetics. If you have questions about specific treatments, please feel free to contact us, as this is a vital part of your ongoing care.

In order to meet your specific needs, we need to gather as much information as possible. Please review the following pages carefully and initial or sign when requested. It is important you read and understand the polices and the obligations we have with each other. Please pay special attention to the information you provide on your Health History, as this is the most valuable resource we use to create your treatment plan.

If you have questions regarding any of the documents, please do not hesitate to ask for clarity. Our team is happy to assist. Thank you for entrusting your dental health to us. We look forward to helping you achieve the best smile and health possible.

Sincerely,

Dr. Byron M. Blasco & Your Dental Team

PATIENT INFORMATION

LAST NAME ______________________________ FIRST __________________________ MI _____ Preferred Name____________

SEX: ☐ MALE ☐ FEMALE IF MINOR, PARENT/GUARDIAN'S NAME____

ADDRESS ____

CITY ____________________________________ STATE __________ ZIP ____________ MARITAL STATUS: S M W D

BIRTHDATE _____/_____/_____ SS# _____-_____-______ EMAIL ____

CELL ________-________-_________ HOME ________-_________-__________ WORK ________-________-________x______

RESPONSIBLE PARTY INFORMATION

LAST NAME ________________________________FIRST _______________________ MI _________ SEX: ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT _____________________ MARITAL STATUS: S M W D SS# ________-______-_________

BIRTHDATE _____/_____/_____ ADDRESS ____

CITY ______________________________ STATE ______ ZIP __________ PPREFERRED METHOD OF CONTACT___________

CELL ______-_________-_________ HOME ________-_________-_________ WORK ________-________-_______X__________

EMAIL ____

EMPLOYER ____

ADDRESS ____

CITY _____________________________ STATE _________ ZIP ____________ PHONE NUMBER ______-_________-_________

EMERGENCY CONTACT

LAST NAME ____ FIRST _______________________________________ MI _________

RELATIONSHIP TO PATIENT ____ PHONE __________________________________

WHO MAY WE THANK FOR REFERRING YOU TO US

LAST NAME ____ FIRST ____

HOW DO YOU KNOW THEM:____