



**Dental Information**

Please place an 'X' next to Yes or No for the questions below

- 1. Date of last dental Visit: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_
- 2. Do you like your smile? \_\_\_Yes \_\_\_No
- 3. Are you interested in Tooth Whitening? \_\_\_Yes \_\_\_No
- 4. Have you have had any complication following dental treatment? \_\_\_Yes \_\_\_No  
If yes please explain: \_\_\_\_\_
- 5. Do you avoid brushing any part of your mouth because of pain or sensitivity? \_\_\_Yes \_\_\_No
- 6. Do you clench or grind your teeth while sleeping or during the day? \_\_\_Yes \_\_\_No
- 7. Are you apprehensive (nervous) about your dental treatment? \_\_\_Yes \_\_\_No

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment without fail.

Signature of patient, parent/guardian: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our practice? Please place an 'X' next to those that apply.

- \_\_\_Another Patient                      \_\_\_Facebook                      \_\_\_Employer
- \_\_\_Newspaper/Magazine              \_\_\_Website/Internet              \_\_\_Insurance Company

Name of the person or office referring you to our practice: \_\_\_\_\_

**Patient Employer**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Dental Insurance Information**

\*Claims cannot be submitted without complete insurance information\*

Insurance Plan Name, Address and Phone #: \_\_\_\_\_

Insurance Subscriber: \_\_\_\_\_

Subscribers Birth date: \_\_\_\_\_ Subscribers ID # \_\_\_\_\_

Group #: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Relationship to Patient: \_\_\_Self \_\_\_Spouse \_\_\_Child Other \_\_\_\_\_

**Consent of Services**

As a condition and your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance form or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment, thereof. I further agree that a waiver of any breach of anytime of condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you and your assignee, to telephone me at home or at any work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature of patient, parent/guardian: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date \_\_\_\_\_