

What are your dental complaints at this time? _____

Date of your last dental cleaning _____ Was treatment completed? ___ Yes ___ No

When was your last full mouth or Panoramic x-ray(s) taken? _____

Are any of your teeth painful or sensitive due to heat, cold, or sweets? _____

Do your gums bleed easily or do they feel irritated, tender, or swollen? _____

Have you ever been told you have gum or periodontal disease or pyorrhea? _____

Do you ever get canker sores or fever blisters in your mouth? ___ Yes ___ No How often? _____

Have you ever had a local anesthetic, (numbing of the jaw)? ___ Yes ___ No

Do you have frequent headaches? ___ Yes ___ No If so, how often? _____

Does your jaw ever pop? ___ Yes ___ No Do you clench your teeth? ___ Yes ___ No

Do you ever have discomfort around your eyes, throat, neck, or shoulder? ___ Yes ___ No

Are you satisfied with the appearance of your teeth? ___ Yes ___ No

How often do you brush your teeth? _____ Floss? _____

Is there any dental condition or previous difficulty with dental treatment that your dentist should know about before receiving treatment? ___ Yes ___ No If so, please explain _____

Whom may we thank for referring you to our office? _____

PAYMENT POLICY: In compliance with the Truth in Lending Law, here is our credit policy: It is customary to pay fees at the time services are rendered unless other arrangements have been made. To assist you with this we will accept cash, check, and most credit cards. On reconstruction cases (crown, bridge, and partial and full dentures) 50% of the fee is due at the first appointment and balance due at time of insertion. If you have dental insurance, we will accept assignment on that portion of your charges which are covered by insurance. However, it must be understood that you will be responsible for any portion of the assigned amount paid by your insurance company within 60 days.

If dental insurance assignment is accepted, I authorize payment to Stanley M. Prince, D.M.D., or any group insurance benefits otherwise payable to me and agree to the release of information relating to this claim.

METHOD OF PAYMENT: I prefer to pay by ___ cash ___ check ___ Credit Card

Primary Dental Insurance Company: _____ Policy#: _____

Subscriber Date of Birth: _____

Person Responsible for Payment: _____ SSN# _____

I agree that I am personally responsible for the payment of all claims incurred on behalf of the above named patient. I also agree in the event it is necessary to refer this account to an agency for collection, I will pay all costs incurred in the collection of the account including, but limited to attorney's fees in the amount of twenty-five percent (25%) of the unpaid balance.

I acknowledge that this information is correct and hereby authorize a dental examination for the above named patient including necessary radiographs, photographs, and acceptable methods to accomplish these services.

Patient Signature

Date