Dental Information and Agreement

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Middleburg Smiles
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PLEASE SELECT ONE BOX ON EACH LINE

If we could show you an easy way to lighten your teeth would you be interested? ❑Tell Me More ❑No

If you could invisibly straighten your teeth would this interest you? ❑Tell Me More ❑No

Do any of your fillings show when you smile? ❑Yes ❑No

Is there anything you would like to change with your teeth or smile? ❑Yes ❑ No _____

Are any of your teeth sensitive? ❑Yes ❑No _____

Does food constantly get stuck between certain teeth? ❑Yes ❑No _____

Do you clench or grind your teeth? ❑Yes ❑No ❑ Not Sure

Do your gums bleed when you brush or floss? ❑Yes ❑No

Do you have an unpleasant taste or odor in your mouth? ❑Yes ❑No

Have you been instructed regarding proper dental care? ❑Yes ❑No

❑I will do whatever I must to keep my teeth ❑I want to keep my teeth but only within a certain budget of time and money

❑I've done the dentistry recommended to me ❑I've NOT done dentistry recommended to me ❑Never been recommended

MY DENTAL HEALTH IS ❑Excellent ❑Good ❑Fair ❑Poor

Is there anything else you would like to share? _____

_____

The information present on these pages is true to the best of my knowledge. If I ever have any change in my health or medications I will inform the doctor at my next appointment. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

Full payment is due at the time of service unless other arrangements are made at the time of scheduling. If the bill for services is not paid within 30 days of billing, the patient is obligated to pay a late fee of $50. In the event the outstanding balance is referred out for collection, the patient agrees they are responsible for all collection fees and/or reasonable attorney fees and court costs incurred in collection, whether suit is filed or not. We are happy to assist you with your insurance by providing you with all the necessary information you and your insurance company need to properly process your claim. To provide you with the best possible care we do not accept assignment of benefits and do not participate with any insurance plans. This removes us from any obligation to the insurance company and allows us to diagnose and treat you based solely on your needs.

We will reserve time for your care; this time is carefully planned based upon your individual needs. We expect that you will assume the responsibility to be on time for your appointments or to make other arrangements 48 hours (two business days) in advance. We will respect your time by appointing you and seeing you in a timely manner so we use as little of your time as necessary. Missed appointments delay necessary treatment for you and for others who need and want to take care of their dental health. The practice may charge up to the full fee for the services planned on the missed appointment and may not reschedule.

I have read and agree to the above: Signature _____Date _____