Amy D. Russell, DMD

1651 Mt. Vernon Rd

Dunwoody, Georgia 30338

770-394-3920

**New Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Responsible Party information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance information:**

Insured’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BirthDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How can we contact you?**

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you prefer to receive calls? ( ) Home ( ) Work ( ) Cell ( ) Email

**Authorization and Release**

I authorize Dr. Amy Russell, DMD to release any information concerning my dental treatment, or my child’s, to a third party payors and/or health practitioners.

Signature of Patient or Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Supplemental Informed Consent/Questionnaire**

**Communicable Diseases and Your Dentist**

With community transmission of communicable diseases, you could be exposed anywhere to infectious diseases including, but not limited to COVID-19 (also called Coronavirus) Our office is following the State and Federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of communicable diseases. However, it is possible that these precautions will not always be successful in blocking the transmission of these diseases. Social distancing nationwide has reduced the transmission of COVID-19; however, it is not possible to provide dental treatment with social distancing between the patient, dentist, staff and sometimes other patients.

 By Presenting yourself or your child for treatment, you assume and accept the risk that you or your child may inadvertently be exposed to a communicable disease.

 If you have been exposed to a communicable disease prior to your appointment, you may spread the disease to the dentist, staff, and to other patients in the practice. Therefore, prior to each appointment, we require you to answer the following questions.

 Have you, your child, or others accompanying you to today’s appointment tested positive or been diagnosed as having COVID-19?

Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you, your child, or others accompanying to today’sd appointment have:

 A fever? Yes\_\_\_\_\_\_ No\_\_\_\_\_

 A Cough? Yes\_\_\_\_\_\_ No\_\_\_\_\_

 Shortness of breath, and/or

 Trouble breathing? Yes\_\_\_\_\_\_ No\_\_\_\_\_

 Persistent pain, pressure or

 Tightness in the chest? Yes\_\_\_\_\_\_ No\_\_\_\_\_

Patient/Parent’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

*Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs.*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you seeking dental treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please answer each questions. If in doubt, leave blank.*

1. Are you in good health? Yes / No, If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Previous Dentist and Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you under the care of a physician? Yes / No, if yes what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you ever been hospitalized or had a serious illness? Yes / No, if yes what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. (Women) Are you pregnant? Yes / No

 If so, when are you due? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you use tobacco in any form? If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you drink alcoholic beverages (more than 2 drinks per day)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever been told to pre-medicate prior to dental work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you or have you ever had any of the following?

**GENERAL HEALTH/BLOOD VESSELS NERVOUS SYSTEM**

Tire easily, weakness Yes / No Stroke Yes / No

Marked weight change Yes / No Headaches Yes / No

Night sweats Yes / No Convulsions/epilepsy Yes / No

Persistent fever Yes / No Dizziness/Fainting Yes / No

**SKIN** Psychiatric treatment Yes / No

Eruptions (rash) hives Yes / No **RESPIRATORY**

Change in skin color Yes / No Tuberculosis Yes / No

**EYES** Emphysema Yes / No

Visual Change Yes / No Asthma/Hay fever Yes / No

Glaucoma Yes / No Persistent Cough Yes / No

**EARS** Sputum production (phlegm) Yes /No

Changes in hearing Yes / No Cough up bloody sputum Yes / No

Hearing impaired Yes / No Difficulty breathing lying down Yes / No

**NOSE ENDOCRINE**

Frequent nosebleeds Yes / No Thyroid condition/ goiter Yes / No

Sinus problems Yes / No Diabetes (including gestational Yes / No

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**HEART BLOOD VESSELS BONE/MUSCLES**

Rheumatic fever Yes / No Arthritis/Rheumatism Yes / No

Heart murmur Yes / No Artificial Joints Yes / No

Chest pain/discomfort Yes / No **DIGESTIVE SYSTEM**

Heart attack/trouble Yes / No Hepatitis Yes / No

Shortness of breath Yes / No Jaundice Yes / No

High blood pressure Yes / No Ulcers Yes / No

Congenital heart disease Yes / No Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Artificial heart valve Yes / No **URINARY**

Pacemaker Yes / No Kidney Disease Yes / No

Heart Surgery Yes / No Increase in frequency of urination (night)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

**BLOOD OTHER**

Anemia Yes / No Radiation Therapy Yes / No

Bruise easily Yes / No Cancer Yes / No

Blood Transfusion Yes / No Tumors or growths Yes / No

 AIDS Yes / No

1. Are you ALLERGIC to or have you ever experience any reaction to the following?

Local anesthetics (e.g., Novocain) Yes / No Aspirin or codeine Yes / No

Sulfa Drugs Yes / No Penicillin/ other antibiotics Yes / No

Barbiturates/sedatives/sleeping pills Yes / No Other drug allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking any of the following?

Antibiotics/sulfa drugs? Yes / No Cortisone/steroids Yes / No

Tranquillizers Yes / No Digitalis/other heart medications Yes / No

Blood thinners Yes / No Nitroglycerin Yes / No

Insulin/other diabetes drugs Yes / No Aspirin Yes / No Antihistamines/allergy/cold medications Yes / No Blood pressure medication Yes / No

Recreation drugs Yes / No Other medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid medication Yes / No

If you answered yes to any of the above, list names of medication and dosage below : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever had any serious trouble associated with previous dental treatment? Yes / No. If so, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Date of last Dental visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last X-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Does dental treatment make you nervous? YES / NO (MILD MODERATE SEVERE)
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?

YES / NO

1. Do you have or have you ever had any of the following?

**MOUTH/ TEETH ORAL HYGIENE**

Bleeding, sore gums Yes / No Do you use the following?

Loose Teeth Yes / No Toothbrush Yes / No

Unpleasant taste/bad breath Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x per day

Sensitive to hot Yes / No

Sensitive to cold Yes / No Dental Floss Yes / No

Sensitive to sweets Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x per day

Frequent blister, lips/mouth Yes / No

Burning tongue/lips Yes / No Fluoride rinse Yes / No

Swelling/ lumps in mouth Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x per day

Sensitive to biting Yes / No

Ortho treatment (braces) Yes / No Tooth brush is: SOFT MEDIUM HARD

Food impaction Yes / No

Biting cheeks/lips Yes / No

Clenching/grinding Yes / No

Clicking/popping jaw Yes / No

Shifting of teeth Yes / No

Difficulty opening or closing jaw Yes / No

Change in bite Yes / No

I consent and authorize Dr. Amy Russell, DMD to use my photographs, video, slides, or any other image as may be necessary of me, with or without my given name, or with a fictitious name for advertising, education, or any other lawful purpose and I release and forever discharge them from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

To the best of my knowledge, all the proceeding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.

Office policies: Please be prompt for you appointment. This time is set aside for you. **Advance notice of 24 hours is required if you must change an appointment or there will be a charge.** All charges for treatment are due at the time said treatment is rendered. For your convenience we accept cash, check, Visa, Master Card, Discover, and American Express.

If you are covered by dental insurance, responsibility for the full charges on your dental services is yours. We will, as a courtesy, fil the claims for you. However, your estimated portion and any deductable must be paid at the time of treatment. It is your responsibility as the insured to be informed of the benefits available to you through your dental insurance coverage.

Signature of patient, parent or guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_