

DENTAL HEALTH QUESTIONS

Due to A.F.D.'s philosophy of reasonable fees it is imperative that the charges incurred for every appointment be paid in full for services rendered. This practice enables us to pass along the savings to all of our patients. On all lab procedures two thirds of the total is requested for processing and the remaining one third to be paid prior to delivery. All implant surgeries require a deposit to hold the appointment.

Why are you here today? _____ Emergency _____

Are you interested in replacing missing teeth? Implants _____ Dentures _____ Crowns _____ Bridges _____

Are your teeth sensitive to> Heat _____ Cold _____ Sweets _____

Does food catch between your teeth? _____

Do your gums bleed when brushing? _____

Have you noticed any gum swelling around your teeth? _____

Do you smoke? _____ Any tooth mobility present? _____ Teeth shifting _____

Are you satisfied with your teeth and their appearance? _____

Do you have bad breath? _____ Last cleaning date _____

When was your last dental appointment? _____

Why did you leave your last Dentist? _____

FINANCIAL ARRANGEMENT?

How are you paying today? Credit card _____ Cash _____ Check _____ Ins. _____ Other _____

Payment options: Payment is due in full at the time if treatment.

Cash or Check: We accept payment by cash or check at the time of the service

Credit Cards: We accept Master Card, VISA, American Express, or Discover card .and Care Credit

Use of credit card authorizes A.F.D. payment in full on Dental balances with signatures on file

Dental Insurance Information

Name of Insurance company _____ Plan # _____

Name of insured _____ Social security # _____

Insured's Birth date _____ Relationship to patient _____

Employer's Name _____ Telephone _____

AUTHORIZATION AND RELEASE

Note all Dentists are independent contractors and carry their own malpractice insurance. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services for my treatment and or diagnosis. It is imperative that all charges incurred for every appointment be paid in full at the time of the appointment. I authorize Atlantic Florida Dental Inc. and its associates perform the necessary surgery and or treatment.

Patient's name (print) _____ Witness, _____

Patient Signature _____ Date _____