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 enables us to maintain our reasonable fees, to be passed on to all our patients. On all lab procedures, two thirds is requested to send the case out for lab work/processing and the remaining balance due day of delivery/insertion. All implant surgeries require a deposit to book the Surgical Appointment.

Why are you here today?_____ Emergency _____

Are you having any Pain now? **YES** **NO** **WHERE ?**_____

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 ? **YES** **NO** Do your gums bleed when brushing? **YES** **NO**

Have you noticed any gum swelling around your teeth ? **YES** **NO**

Do you Smoke? **YES** **NO** Any tooth mobility present? **YES** **NO** Teeth shifting **YES** **NO**

Are you satisfied with your teeth and their appearance ? **YES** **NO**

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? Please circle: Credit card Cash Check Ins Other
PLEASE SEE WRITTEN FINANCIAL POLICY ATTACHED
Payment options: Payment in full at the time of treatment:
We accept Mastercard, Visa , American Express, Discover, Care Credit, Debit cards
USE OF CREDIT CARD AUTHORIZES A.F.D.INC, PAYMENT IN FULL WITH SIGNATURE ON FILE.

DENTAL INSURANCE INFORMATION

Name of Insurance company _____ ID # _____

Name of Insured _____ Insured Date of Birth _____

Relationship to patient _____ Employer _____ Phone # _____

AUTHORIZATION AND RELEASE

Note all Dentist are Independent contractors and carry their own malpractice insurance. I understand that the information that I have given today is accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history or contact information, Insurance, etc.. 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 ever appointment be paid at that appointment. I authorize Atlantic Florida Dental, Inc. and its staff to perform the necessary surgery and or treatment.

Patient's name (print)_____ Witness _____

Patient Signature _____ Date _____