

## CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

As a courtesy, our office will call to remind you of your appointment 48 hours in advance. Please be considerate to our doctors, hygienists, and our other patients waiting for an appointment by giving us 48 hour advance notice of any change in your scheduled appointment. We understand that emergencies may arise that will result in cancellation. Please understand that we cannot guarantee that you will be appointed to the same time slot. We may require advance payment of your appointment if cancellations occur greater than two (2) times (or become habitual).

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

In order to continue to assist our patients with dental insurance, we require that patients have a credit card on file in our office. Once insurance has paid their portion, your credit card will be charged the balance. If we have not received payment from your insurance company within 60 days after filing your claim, your credit card will be charged for the outstanding balance. For your convenience, we accept the credit cards listed below, as well as personal checks, third-party financing with CareCredit, and cash. As always, we extend a courtesy discount to our patients who pay in full at the time of service and have their insurance company reimburse them. This courtesy applies to restorative treatment only. We are happy to file all necessary paperwork to your insurance company to support your claim. Our team is also here to assist you with all third-party applications if you are interested in applying for financing. Please be assured that our office protects your personal and financial information as regulated by the Health Insurance Portability and Accountability Act of 1996 or HIPPA. Patients who choose not to leave a valid credit card on file with our office understand they must pay for their dental care in full on the day of service, and insurance will be filed to reimburse them for their services according to their schedule of benefits. Your signature below authorizes our office to charge your credit card.

Credit Card:  Visa  MasterCard  Discover  American Express

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

signature of patient, parent, guardian, or guarantor of payment      date      relationship to patient

signature of guarantor of payment/responsible party      date      relationship to patient

## WELCOME TO MINT32

*Dentistry design for your perfect smile.* We're pleased to have you as a client and want to assure you that we intend to do everything possible to ensure your comfort and confidence in our services. We strive to provide the highest quality care using only the very best, proven techniques and materials — while catering to your ultimate relaxation in a pampering, nurturing environment.

Please take a few minutes to complete the following profile. This information is required and will be considered strictly confidential.

Again, welcome to Mint 32!

Dr. Darrell Morton  
& The Mint32 Staff

## ABOUT YOU

first name	middle initial	last name	I prefer to be called		
date	birthdate	social security #	email address		
<input type="radio"/> male	<input type="radio"/> female	<input type="radio"/> single	<input type="radio"/> married	<input type="radio"/> partnered	<input type="radio"/> other
address					
city		state	zip		
home phone	cell phone / other	work phone	ext.		
employer	occupation		how long		
employer's address					
how did you hear about us?      whom may we thank and reward for referring you?					

## YOUR DENTAL APPEARANCE

are you delighted with your smile  yes  no what would you change? rate your smile from 1-10 (10=awesome)

would you like to have whiter teeth  yes  no what personal/professional benefit might you gain with a perfect smile

do you need dental work completed in time for an upcoming special occasion (please explain)

Please check the procedures below that you feel would improve your smile:

- lighten all front teeth showing  lengthen certain teeth  eliminate crowding
- lighten single tooth  shorten certain teeth  eliminate dark/stained fillings
- close spaces between teeth  straighten rotation  reduce gum showing in smile
- rebuild fracture (s)  straighten angulation  repair uneven edges

## YOUR DENTAL HISTORY

why have you come to our office today

previous dentist

city and state

date of last dental exam	were x-rays taken	was treatment recommended	was treatment completed
are you currently in pain	<input type="radio"/> yes <input type="radio"/> no	If so, where? _____	
do you floss daily	<input type="radio"/> yes <input type="radio"/> no	_____	
do you brush daily	<input type="radio"/> yes <input type="radio"/> no	_____	
do you have bad breath	<input type="radio"/> yes <input type="radio"/> no	_____	
have you ever had gum treatment	<input type="radio"/> yes <input type="radio"/> no	_____	
do you breathe thru your mouth while awake or asleep	<input type="radio"/> yes <input type="radio"/> no		
do you gums bleed	<input type="radio"/> yes <input type="radio"/> no		
do you experience pain when cleaning teeth	<input type="radio"/> yes <input type="radio"/> no		
have you ever had periodontal disease	<input type="radio"/> yes <input type="radio"/> no	If so, when? _____	
have you ever been under the care of a periodontist	<input type="radio"/> yes <input type="radio"/> no	Name of Periodontist/city _____	
do you have mobility in your teeth	<input type="radio"/> yes <input type="radio"/> no		
are your teeth sensitive to temperature or pressure	<input type="radio"/> yes <input type="radio"/> no		
have you ever had pain in either jaw joint	<input type="radio"/> yes <input type="radio"/> no		
do you have chronic headaches, neck or shoulder pain	<input type="radio"/> yes <input type="radio"/> no		
do you require antibiotics before dental treatment	<input type="radio"/> yes <input type="radio"/> no		
are you aware of any sores or growths in your mouth	<input type="radio"/> yes <input type="radio"/> no	If so, when: <input type="radio"/> opening <input type="radio"/> closing	
are you aware of clicking or popping in either jaw joint	<input type="radio"/> yes <input type="radio"/> no	If so, when: <input type="radio"/> while awake <input type="radio"/> while asleep	
do you clench or grind your teeth	<input type="radio"/> yes <input type="radio"/> no		
have you ever had complications after dental treatment	<input type="radio"/> yes <input type="radio"/> no		
would you like to speak to the doctor privately	<input type="radio"/> yes <input type="radio"/> no		

## YOUR MEDICAL HISTORY

do you have a personal physician  yes  no are you currently under the care of a physician  yes  no

physician's name \_\_\_\_\_ physician's phone number \_\_\_\_\_ under care of physician for (explain) \_\_\_\_\_

your current health is:  excellent  good  fair  poor date of last physician visit: \_\_\_\_\_

do you smoke or use tobacco in any form:  yes  no are you taking any prescription/over the counter drugs (list all)

are you taking birth control pills:  yes  no are you pregnant:  yes  no week # \_\_\_\_\_ are you nursing:  yes  no

have you ever had any of the following diseases or medical conditions:

- abnormal bleeding  yes  no HIV  yes  no
- AIDS  yes  no jaundice  yes  no
- alcohol/drug abuse  yes  no kidney disease  yes  no
- anemia  yes  no liver disease  yes  no
- arthritis  yes  no low blood pressure  yes  no
- artificial bones/joints/valves  yes  no mental/psychiatric problems  yes  no
- asthma  yes  no nervous disorders  yes  no
- cancer  yes  no pacemaker  yes  no
- diabetes  yes  no radiation treatment  yes  no
- difficulty breathing  yes  no respiratory problems  yes  no
- dizziness/fainting spells  yes  no rheumatic/scarlet fever  yes  no
- eating disorder  yes  no rheumatism  yes  no
- epilepsy  yes  no seizures/convulsions  yes  no
- frequent headaches  yes  no shingles  yes  no
- glaucoma  yes  no sickle cell disease/traits  yes  no
- hay fever  yes  no sinus problems  yes  no
- head or neck injury  yes  no steroid therapy  yes  no
- heart disease/defect  yes  no stroke  yes  no
- heart murmur  yes  no thyroid disease  yes  no
- hemophilia  yes  no tuberculosis  yes  no
- hepatitis  yes  no tumors  yes  no
- herpes/fever blisters  yes  no ulcers  yes  no
- high blood pressure  yes  no venereal disease  yes  no

are you allergic to any of the following:

- aspirin  yes  no latex  yes  no
- codeine  yes  no penicillin  yes  no
- novocaine  yes  no tetracycline  yes  no
- erythromycin  yes  no other (describe below)  yes  no
- jewelry/metals  yes  no

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

signature of patient, parent, or guardian

date