SUNBRITE DENTAL

Date:________________

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name	I prefer to be called	Social Security Number
Home Address	City, State, Zip	Home Phone
Email Address	Cell Phone	Work Phone
Marital Status ❒ Single ❒ Divorced ❒ Married ❒ Separated ❒ MALE ❒ FEMALE	Birthdate	Drivers License and State
Your pharmacy name and location (i.e. cross streets)		

Why have you come to see us today? (e.g.: pain, checkup, etc.)		
Previous Dentist	Last Visit	Date of last cleaning
Reasons for changing dentists:		
Which days of the week you prefer to have your dental appointments? ❒Su ❒M ❒T ❒W ❒Th ❒F ❒S	Are you nervous about seeing a dentist? ❒ No ❒Yes, if yes please, tell us why:	
How often do you brush?	Do you floss? ❒ Yes ❒ No How often?	

❒Y ❒N My gums bleed while brushing or flossing.
❒Y ❒N I would like to improve my smile.
❒Y ❒N I prefer tooth-colored fillings.
❒Y ❒N I avoid brushing part of my mouth due to pain.
❒Y ❒N My gums feel tender or swollen
❒Y ❒N I have problems eating.
❒Y ❒N I have had orthodontics.
❒Y ❒N I want my teeth straighter.
❒Y ❒N I want my teeth whiter.

What are your dental priorities?
(e.g.: appearance, dental health, financial considerations, etc)

How did you hear about our Office? (check only one)

❒ Referred by a friend/relative ❒ Google ❒ Yelp ❒ Better Business Bureau
❒ Insurance Plan ❒ Postcard/Mailer ❒ Sign by Building ❒ Other______________________

If you were referred, whom may we thank for referring you?______________________

CONSENT

*I will answer all health questions to the best of my knowledge ____________
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

______________________________ ______________________________
*Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an Insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this dental office benefits accruing to me under my policy. I understand that the fee estimate given for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed______________________________Date______________

THERE MAY BE A CHARGE FOR ANY MISSING APPOINTMENTS OR APPOINTMENTS NOT CANCELED 24 HOURS BEFORE THE APPOINTMENT TIME.