

- Are you interested in whitening your teeth? Yes No
- If you could change your smile, what would you do? _____
- Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
 Yes No

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Robinson at the next appointment without fail.

Signature of patient, parent, or guardian

Date

<u>Insurance Information</u>	
Name of Insured: _____	Insurance Co. Name: _____
Insured's Birth Date: _____	Social Security #: _____
Patient's relationship to insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	
Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment.	
_____ Signature of patient, parent, or guardian	

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.

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 patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 Dr. Robinson 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.

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

I agree to have any photos taken of me to be used for education, training, and/or promotional.

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

Signature of patient, parent or guardian

Date

Relationship to Patient