TAMER AZIM, DDS PC
PROSTHODONTIST

586 Washington Street
San Francisco, CA 94111

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www.sfdentist.org
info@sfdentist.org

Dental Health History Form

Today's Date _____

Patient Name *(First, MI, Last)* _____ Date of Birth_____

Address: *Street* _____

*City*_____ *State*_____ *Zip*_____

Phone: *Cell*_____ *Home*_ _____ *Work* _____

Can we text you for confirmation? ☐ Yes ☐ No

Email _____

Would you prefer contact by text or email? ☐ Text ☐ Email

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past?_____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former Dentist _____ Phone Number _____

Address *(Street, City, State, Zip)* _____

_____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now?

If yes, please describe _____

Have you ever been pre-medicated for dental treatment?

If yes, why? _____

Have you been anxious about having dental treatment?

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? *(check all that apply)*

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings (gold or silver)
- ☐ Old crowns
- ☐ Speech Problems
- ☐ Too much gum tissue when I smile
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food gets caught in between teeth
  If yes, Where?_____
- ☐ Difficulty in chewing
  If yes, Where?_____
- ☐ Bad Breath
- ☐ Other _____

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?

☐ Yes ☐ No

If yes, when? _____

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, when? _____

Are you interested in learning more about the following? *(check all that apply)*

- ☐ Teeth Whitening
- ☐ Orthodontic treatment
- ☐ Veneers
- ☐ Tooth-colored fillings
- ☐ Dental implants
- ☐ How to prevent periodontal disease
- ☐ At-home oral hygiene care
- ☐ Periodontal treatment during pregnancy
- ☐ Oral hygiene care for infants and toddlers

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Confidential Health History

I. Check appropriate answer

Is your general health good? ☐ Yes ☐ No

If NO, explain: _____

Has there been a change in your health within the last year? ☐ Yes ☐ No

If YES, explain: _____

Have you gone to the hospital or emergency room or had a serious illness in the last three years? ☐ Yes ☐ No

If YES, explain: _____

Are you being treated by a physician now? ☐ Yes ☐ No

If YES, explain: _____

Date of last medical exam _____ Reason for exam: _____

_____

II. Have you ever experienced any of the following? (*check all that apply*)

Chest pain (angina)
- ☐ Fainting spells
- ☐ Recent significant weight loss
- ☐ Fever
- ☐ Night sweats
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Bleeding problems
- ☐ Blood in urine
- ☐ Other:

Blood in stools
- ☐ Diarrhea or constipation
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Ringing in ears
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Bruise easily
- ☐

Frequent vomiting
- ☐ Jaundice
- ☐ Dry mouth
- ☐ Excessive thirst
- ☐ Difficulty swallowing
- ☐ Swollen ankles
- ☐ Joint pain or stiffness
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐

_____

III. Are you allergic to or have you had a reaction to any of the following? (*check all that apply*)

- ☐ Aspirin
- ☐ Penicillin or other antibiotics
- ☐ Nitrous oxide
- ☐ Valium or other sedatives
- ☐ Latex
- ☐ Local anesthetic
- ☐ Codeine or other narcotics
- ☐ Food
- ☐ Metal

Other: _____

IV. Have you ever had or do you have any of the following? (*check all that apply*)

- ☐ Heart disease
- ☐ Family history of heart disease
- ☐ Heart attack
- ☐ Artificial joint
- ☐ Stomach problems or ulcers
- ☐ Heart defects
- ☐ Heart murmurs
- ☐ Rheumatic fever
- ☐ Skin disease
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Seizures
- ☐ Cosmetic surgery
- ☐ AIDS/HIV
- ☐ Surgeries
- ☐ Hospitalization
- ☐ Diabetes
- ☐ Family history of diabetes
- ☐ Tumors or cancer
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Arthritis, rheumatism
- ☐ Emphysema or other lung disease
- ☐ Kidney or bladder disease
- ☐ Stroke
- ☐ Eating disorders
- ☐ Psychiatric care
- ☐ Osteoporosis
- ☐ Thyroid disease
- ☐ Asthma
- ☐ Hepatitis
- ☐ Sexual transmitted disease
- ☐ Herpes
- ☐ Canker or cold sores
- ☐ Anemia
- ☐ Liver disease
- ☐ Eye disease
- ☐ Transplants
- ☐ Tuberculosis

Other: _____

V. Are you taking or have you taken any of the following in the last three months? (*check all that apply*)

- ☐ Recreational drugs
- ☐ Over-the-counter medicines
- ☐ Weight loss medications
- ☐ Anti-Depressants
- ☐ Tobacco in any form
- ☐ Alcohol
- ☐ Bisphosphonate (Fosamax)
- ☐ Herbal supplements
- ☐ Antibiotics
- ☐ Supplements
- ☐ Aspirin

Other: _____

VI. Woman only (*check all that apply*)

- ☐ Are you or could you be pregnant? If YES, what month? _____
- ☐ Are you nursing?
- ☐ Are you taking birth control pills?

VII. All patients (*check all that apply*)

- ☐ Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:_____

_____

- ☐ Have you ever been pre-medicated for dental treatment? If YES, why: _____
- ☐ Have you ever taken Fen-Phen? If YES, when: _____
- ☐ Is there any issue or condition that you would like to discuss with the dentist in private?

If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____

Physician's Signature_____

Date _____

Phone Number _____

Whom would you like us to contact in case of an emergency?

Name:_____ Relationship:_____ Phone Number:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) **Date**

Signature of Dentist **Date**

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Dentist	Patient Signature	Changes to Health History	Dentist Signature

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The Facts About Fillings

DENTAL BOARD OF CALIFORNIA

www.dbc.ca.gov

Dental Materials Fact Sheet

What About the Safety of Filling Materials?

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

** Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth- colored and is used in inlays, veneers, crowns and fixed bridges.

Advantages

- Very little tooth needs to be removed for use as a veneer; more tooth needs to be re-moved for a crown because its strength is related to its bulk (size)
- Good resistance to further decay if the restoration fits well
- Is resistant to surface wear but can cause some wear on opposing teeth

- Resists leakage because it can be shaped for a very accurate fit
- The material does not cause tooth sensitivity

Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT-CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

Advantages

- Good resistance to further decay if the restoration fits well
- Excellent durability; does not fracture under stress
- Does not corrode in the mouth
- Minimal amount of tooth needs to be removed
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth

GLASS IONOMER CEMENT

Glass ionomer cement is a self- hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer is usually used for small fillings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

Advantages

- Reasonably good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended for biting surfaces in permanent teeth

- As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

RESIN-IONOMER CEMENT

Resin ionomer cement is a mixture of glass and resin polymer and organic acid that hardens with exposure to a blue light used in the dental office. It is tooth colored but more translucent than glass ionomer cement. It is most often used for small fillings, cementing metal and porcelain metal crowns and liners.

Advantages

- Very good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Good for non-biting surfaces
- May be used for short-term primary teeth restorations
- May hold up better than glass ionomer but not as well as composite
- Good resistance to leakage
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and
- amalgam

Toxicity of Dental Materials

Dental Amalgam

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam is created by mixing elemental mercury (43-54%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

DENTAL AMALGAM FILLINGS

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages

- Durable; long lasting
- Wears well; holds up well to forces of biting
- Relatively inexpensive
- Generally completed in one visit
- Self-sealing; minimal-to-no shrinkage and resists leakage
- Resistance to further decay is high, but can be difficult to find in early stages
- Frequency of repair and replacement is low

Disadvantages

- Refer to "*What About the Safety of Filling Materials*"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold.
- Contact with other metals may cause occasional, minute electrical flow

COMPOSITE RESIN FILLINGS

Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

A*dvantages*

- Strong and durable
- Tooth colored
- Single visit for fillings

- Resists breaking
- Maximum amount of tooth preserved
- Small risk of leakage if bonded only to enamel
- Does not corrode
- Generally holds up well to the forces of biting depending on product used
- Resistance to further decay is moderate and easy to find
- Frequency of repair or replacement is low to moderate

Disadvantages

- Refer to "*What About the Safety of Filling Materials*"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

I have read and understand the facts about fillings.

Patient or Patient's Representative's Signature **Date**

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Notice of Privacy Practices

This Notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect _____[date], and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. For more information about our privacy practices or additional copies of this Notice, please contact us at 586 Washington St. San Francisco, CA 94111.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment:

We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:

We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:

We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care:

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services:

We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:

If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law:

We may use or disclose your health information when we are required to do so by law.

Public Health:

We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect:

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security:

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:

We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:

Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access:

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting:

You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction:

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication:

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification:

In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment:

You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: _____

Telephone: _____ Fax: _____

Email: _____

Address: _____

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

I have read and reviewed the notice of privacy practices. I understand and agree. I acknowledge that I have received a copy of the HIPPA notices of privacy practices

_____

Name

_____

Signature **Date**

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Office Policy

We are committed to providing our patients with the best dental care possible, which includes an open dialogue of our fees and financial policies This agreement provides a written statement of our policies and procedures; any questions can be discussed with a member of our front-desk staff.

1. Payments. It is customary to pay in full for all services rendered on the same date of service. For your convenience, we accept: cash, checks, Visa, MasterCard, American Express, Discover and bank-issued debit cards.

2. Dental Insurance. Your insurance policy is a contract between you and your insurance company. As dental care providers, we want to emphasize that our relationship is with you, not your benefit provider. Pre-authorizations to your insurance company are happily provided upon request. We will work with you to achieve the maximum benefits for your coverage without compromising your dental health. Claim forms to your benefit provider will be prepared and mailed as courtesy to you.

3. Treatment Plan Estimate. Once we have diagnosed your dental health, we will present you with a written treatment plan that provides a detailed estimate of our total services. The estimate of fees is guaranteed for sixty (60) days, after which fees are subject to change.

4. Late Fees. Should your account exceed sixty (60) days, one and one-half percent (1.5%) interest per month (18% per year) will be charged on the outstanding balance. In the event your account exceeds ninety (90) days, you will be sent to a collections agency and /or small claims court. Any costs incurred by our practice that are associated with the default of payment will be your responsibility. By signing below you agree to be responsible for all attorneys' fees and other court costs associated with enforcing this agreement.

5. Returned Checks. Checks returned for any reason are subject to a "returned check charge" of $35.00. We will require cash or money order as payment for the check +$35 fee.

6. Cancelled Appointments. Every time you schedule an appointment, staff, operatory space, materials and the doctor's time have been set aside and reserved for you. If you experience a true emergency and cannot keep your appointment, kindly give us as much notice as possible. Please note that failed appointments or late-notice cancellations/rescheduling with insufficient notice [within two (2) Business Days of the scheduled appointment time] may be subject to a charge of $95.00.

I have reviewed the above terms and agree to be fully responsible for payments of treatment provided by this office. Further, I authorize this office to file claims to my insurance carrier on my behalf.

Patient or Parent/Guardian **Date**

Cell Phone:

☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include area code) _____ Initial _____