DATE_____

PATIENT NAME_____ BIRTHDATE_____SEX--M_____F_____

PREFERRED NAME_____SS#_____

ADDRESS_____CITY_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

MARITAL STATUS_____NAME OF SPOUSE_____

EMAIL ADDRESS_____

NAME OF RESPONSIBLE PARTY ON ACCOUNT_____

IF CHILD UNDER AGE 21, NAMES OF BOTH PARENTS_____

CHECK YOUR PREFERENCE FOR REMINDER CALLS

HOME PHONE_____CELL PHONE_____WORK PHONE_____

LIST NAMES OF THOSE YOU ALLOW TO HAVE ACCESS TO YOUR PATIENT RECORDS_____

PATIENT EMPLOYED BY_____BUSINESS ADDRESS_____ __

PRESENT POSITION_____HOW LONG_____

SPOUSE/PARENT EMPLOYED BY_____PHONE_____

BUSINESS ADDRESS_____PRESENT POSITION_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____

PHONE NUMBERS OF EMERGENCY CONTACT-CELL_____HOME_____WORK___

NAME OF YOUR PHYSICIAN_____

HOW DID YOU HEAR ABOUT OUR OFFICE? PLEASE CHECK-MARK.

FACEBOOK__SUBDIVISION NEWSLETTER__GOOGLE__WEBSITE__SIGN__OTHER__

NAME OF PERSON WHO REFERRED YOU TO OUR OFFICE_____

PRIVACY POLICY

A COPY OF THE PRIVACY POLICYAVAILABLE AT CHECK IN. PLEASE SIGN THIS ACKNOWLEDGEMENT IN ORDER FOR US TO PROCESS YOUR INSURANCE. YOU MAY REFUSE TO SIGN, AND SELF PAY.

I_____have reviewed a copy of this office's notice of privacy practices for myself or my minor child (name of child)_____.

_____

(SIGNATURE)

I AUTHORIZE RELEASE OF INFORMATION RELATING TO ANY INSURANCE CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT AND THAT IT IS MY RESPONSIBILITY TO VERIFY MY INSURANCE AND UNDERSTAND MY COVERAGE. I AUTHORIZE INSURANCE PAYMENT DIRECTLY TO JAMIE L. THURMAN-TAYLOR DDS OR KEELEY TREECE DDS, OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT THERE IS A $25 RETURNED CHECK FEE AND THAT I WOULD BE ON A CASH ONLY BASIS THEREAFTER. I UNDERSTAND THAT IF I AM TURNED TO A COLLECTION AGENCY BY THIS OFFICE IT WILL BE AT THE DISCRETION OF TLC FAMILY DENTISTRY TO ACCEPT ME BACK INTO THE PRACTICE AND THAT THERE WOULD BE A SERVICE FEE FOR REINSTATEMENT APPLIED TO MY ACCOUNT. I ACKNOWLEDGE THAT IF INSURANCE COVERS ONLY PART OF THE DENTAL TREATMENT THE PATIENT PORTION WILL BE COLLECTED AT THE TIME OF THE APPOINTMENT.

_____

SIGNATURE DATE

Smile Evaluation

At TLC Family Dentistry we are committed to helping you discover and obtain the smile you have always wanted. Please take a moment to compete this questionnaire. This information helps us ensure we are serving you to the best of our ability.

Do you ever experience **dry** mouth?

_____

Are you happy with the way your teeth look when you **smile**?

_____

Are you happy with the **color** of your teeth?

_____

Do you have any **spaces** between your teeth that you are unhappy with?

_____

Are your teeth….. Chipped?_____ Protruding?_____Crowded?_____

Are you happy with the way your teeth **fit together** when you bite?

_____

Do you **grind** or **clench** your teeth? _____During the day or night?_____

Do you have any **old fillings** or treatment you are unhappy with?

_____

Is there anything you would **change** about your smile?

_____