DENTAL HISTORY

Previous Dentist _____ Location _____

Approximate Date of Last Exam _____

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	____	____	Do you have frequent headaches?	____	____
Are your teeth sensitive to sweet foods?	____	____	Do you clench or grind your teeth?	____	____
Are you teeth sensitive to cold/hot foods?	____	____	Do you or have you ever Worn a denture or partial?	____	____
Do you feel pain in any of your teeth?	____	____	If yes, last date of placement _____		
			Have you ever worn braces?	____	____
Have you ever had any head, neck, or jaw injuries?	____	____	Do you have any sores or lumps in or near your mouth?	____	____
Have you ever had any discomfort w/ your jaw joint or difficulty opening & closing?	____	____	Do you like your smile?	____	____

FINANCIAL POLICY

Our primary mission is to deliver the best & most comprehensive dental care available. An important part of this mission is making the cost of optimal care as manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS

You can choose from:

* Cash, Check, Visa, MasterCard, or Discover

For our patients who do not have dental insurance, at your request, we will offer a 5% courtesy adjustment when you pay for treatment with cash or check on the day service is rendered.

*Payment Plans from CareCredit

- Give you the option of paying over time with NO INTEREST.
- Convenient, low monthly payment plans also available.
- NO annual fees or pre-payment penalties.

PLEASE NOTE:

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50 may be charged to patients who miss or cancel appointments without 24 hrs notice. (Notice must be given Mon-Fri.)

For appointments over 1 hour long, we may require half of your payment when scheduling in order to reserve your space.

Hilliard Modern Dental charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment you want and need.

_____

Patient, Parent or Guardian Signature Date