Patient Information:

1. What is the purpose of this dental visit? _____
2. Are you having any pain or discomfort? yes no
3. List all dental complains or concerns: _____
4. Are you nervous about dental treatment? yes no
5. Have you had a bad dental experience? yes no
6. How long ago was your last dental exam or cleaning? _____
7. How did you hear about us: _____
8. Are you happy with your smile? yes no

   If no, why? _____
9. Are your teeth sensitive to: a) sweets? Y / N b) cold? Y / N c) air? Y / N

Who would you like us to contact in case of emergency?

_____

Name Phone

I authorize Parkview Dental to share my personal medical and billing information with: _____

Initial

_____

Name Phone

PARKVIEW DENTAL POLICIES

Account balances greater than 90 days are subject to a 1.5% finance charge. In the event that collection efforts become necessary I agree to pay any and all reasonable collection costs up to 40% of the amount owed, plus court costs and reasonable attorney fees. We accept cash, check, and credit cards. We also accept Care Credit, a no interest and extended-payment plan (some limitations may apply, please consult our business manager for additional details.) I authorize dental treatment after said treatment has been explained to me. I agree to be responsible for payment of services rendered on my behalf or my dependents.

I understand that failure to provide 24 hour notice prior to canceling an appointment will result in a $40.00 Fee. Parkview Dental reserves the right to reschedule patients arriving 15 minutes after scheduled appointment.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE POLICIES.

_____ _____

Signature of person responsible for this account Date