Andrew B Wurtz DDS

REASON FOR VISIT

Have you ever had any of the following?

Yes No Pain in any of your teeth :

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IF YES PLEASE EXPLAIN

Yes No Dissatisfaction with the appearance of your teeth :

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IF YES PLEASE EXPLAIN

Yes No Tooth sensitivity to hot, cold, sweet or sour liquids/foods:

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IF YES PLEASE EXPLAIN

Yes No TMJ (jaw joint near ear or side issues such as pain Clicking difi opening closing or chewing:

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IF YES PLEASE EXPLAIN

Yes No Dentures or partials:

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IF YES DATE OF PLACEMENT

Yes No Any difficult extractions:

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IF YES PLEASE EXPLAIN

Yes No Bleed while brushing or flossing

Yes No Received oral hygiene instruction

Yes No Been told you need deep scaling

Yes No Head, neck or jaw injuries

Yes No Frequent Headaches

Yes No Lumps, bumps or sores in or near your mouth

Yes No Clenching or grinding of your teeth

Yes No Frequent biting of lips or cheeks

Yes No Do you like your smile

Consent for Services and Financial Arrangements

I have been provided with and reviewed a copy of this office's "Information Privacy Policy". I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I grant my permission to the Dentist or Staff to contact me to discuss matters related to this form or my treatment.

I authorize the taking of radiographs, photographs or other diagnostic procedures necessary for a thorough evaluation. I authorize dental treatment to be rendered by the Dentist or appropriately licensed staff member.

I agree to pay for all services rendered on my behalf or my dependants in this office. I understand that all emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

I 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 patient's account. I authorize and request my insurance company to pay directly to the dentist. I do understand this dental office cannot render services on the assumption that all charges will be paid by an insurance company.

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

______________________________ Date: ______________
SIGNATURE OF PATIENT, PARENT OR GUARDIAN