

Do you have missing teeth that haven't been replaced?..... Yes No

If missing teeth have been replaced are you unhappy with your result?..... Yes No

Would you like to know more about your options for tooth replacements?..... Yes No

We have found that many adults are unaware that they even have problems. There are rarely symptoms (pain, bleeding) associated with the aging & deterioration of teeth and gums – until it is far too late. We respect your right to choose the level of care that fits you. We would be happy to explain the choices available to you to achieve a healthy beautiful smile.

*Please Check All That Apply:*

- |  |   |
|--|---|
| <input type="checkbox"/> I desire to keep my mouth in optimal health with the most attractive long lasting dentistry available.<br>I want to specifically improve the condition of :<br><input type="checkbox"/> My Smile<br><input type="checkbox"/> My gums/oral health<br><input type="checkbox"/> My Teeth<br><input type="checkbox"/> Improve function/stop breakdown<br><input type="checkbox"/> I want to maintain my mouth at its current level of health and to restore decay & worn out dentistry.<br><input type="checkbox"/> I am interested in pain relief/addressing an immediate issue. | <input type="checkbox"/> I would like to address all areas of concern now.<br><input type="checkbox"/> I would like to phase treatment, according to priority, in order to achieve the excellent results I desire.<br><input type="checkbox"/> I would like to address specific areas now and look at the big picture later.<br><input type="checkbox"/> I only want to focus on one area of concern. |
|--|---|

When would you like to start treatment?

- As Soon As Possible       \_\_\_\_\_       As Necessary

How soon would you like your dentistry to be completed?

- As Soon As Possible       \_\_\_ Months       \_\_\_\_\_

I hereby authorize necessary X-Rays and other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of my own or my dependent's needs. I further authorize the doctor to perform any treatment or administer medications that may be indicated. (All of which will be explained to me prior to proceeding).  
 I agree to pay for services rendered and if necessary any collection costs and 1.5% monthly interest.

Patient: X \_\_\_\_\_ Date: \_\_\_\_\_

Witness: X \_\_\_\_\_ Date: \_\_\_\_\_

Parent or responsible party (If patient is a minor): X \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date: \_\_\_\_\_