Welcome to Luna Dental!

In order to serve you properly, we need the following information.
All information is strictly confidential. ***(Please print clearly)*** Date: ____________

GENERAL

Patient's Name: ____________ (First) ____________ (Last) Sex (M/F) ______ Birth date: ____________

Address: ____________ City: ____________ State: ______ Zip: ________

Home Phone No.: (___) ____________ Work Phone No.: (___) ____________ Cell No. (___) ____________

Driving License No. ____________ Soc. Sec. No.: ____________ Referred By: ____________

Email: ____________ Occupation: ____________ Marital Status: ________

Person Responsible for the Account – Name: ____________ (First) ____________ (Last)

Relationship to Patient: ____________ Birth Date: ____________ Soc. Sec. No.: ____________

Address: ____________ City: ____________ State: ______ Zip: ________

Home Phone No.: (____) ____________ Work Phone No.: (____) ____________ Pager No.: (____) ____________

DENTAL HISTORY

Chief Complaint / Reason for Visit: ____________

When Was Your Last Dental Visit? ____________ Last Full Mouth X-Ray? ____________ Last Teeth cleaning? ____________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? – (PLEASE CHECK ALL THAT APPLY)

☐ Teeth Sensitive to Cold, Heat, Sweet and Pressure	☐ Teeth Grinding or Clenching	☐ Broken or Chipped Tooth
☐ Bleeding Gums? How Long? ________	☐ Pain Around Ear, Neck & Shoulder	☐ Finger Nail Biting, Cheek Biting
☐ Food Impaction	☐ Unusual Sounds in Ear While Eating	☐ Frequency of Brushing ________
☐ Bad Breath	☐ Orthodontic Treatment	☐ Dental Floss
☐ Mouth Breathing	☐ Periodontal Treatment	☐ Water Jet Device
☐ Cigarettes, Pipe or Cigar Smoking	☐ Partial or Complete Denture	☐ Professional Teeth Whitening

Are You Satisfied With Your Teeth's Appearance? ____________

Please Add Anything You Feel Is Important: ____________

INSURANCE

Do You Have Insurance or Dental Plan? ☐ Yes ☐ No Insurance Company Name: ____________ Plan: ____________

Employer: ____________ Employer address and number: ____________

Name of Insured: ____________ ☐ ☐ Relationship to Patient: ____________ Soc. Sec. No. ____________

Do You Have Any Other Dental Insurance? Yes No If Yes, Insurance Company Name: ____________ Plan: ____________

I authorize the release of any medical/dental/personal information necessary to process dental claim, and I authorize payment of dental benefit to the Zaragoza Dental Care PLLC. / Sunny Smiles for professional services rendered.

Signature: ____________

I authorize the dental staff to perform any necessary dental service(s) with my informed consent that I may need during diagnosis and treatment. I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. It is customary to pay for services when rendered, unless other arrangements have been made in advance. If account is not paid within 90 days of the date of service I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.
I acknowledge that I have received a copy of the "Dental Material Fact Sheet as required by law.
I acknowledge that I have received a copy of the "Notice of Privacy Practices".

Signature: ____________

Thank you for choosing our office!

MEDICAL HISTORY

Patient Name: Birth Date: Date Created:

LUNA DENTAL

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________

Informed Consent

General Dentistry

Patient Name: ___________________________________ Chart #: _______________

All Patients complete 1 through 4 below and 5 through 14 as needed

1. **EXAMINATION AND X-RAYS**
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

Initials__________ Date ___________

2. **DRUGS, MEDICATION AND SEDATION**
I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. The medication may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree to not operate and vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of any condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

Initials__________ Date___________

3. **CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials __________ Date ___________

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

Initials __________Date ___________

5. **DENTAL PROPHYLAXIS (CLEANING)**
I understand the treatment is preventive in nature, intended for patients with healthy gums and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

Initials __________ Date ___________

6. **FILLINGS**
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

Initials __________Date ___________

7. **REMOVAL OF TEETH & RIDGE PRESERVATION**
Alternatives to tooth removal have been explained to me (root canal therapy, crown and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth___________________________ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Pasathesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. Ridge preservation procedure has been explained to me. I understand ridge preservation limits the loss of bone following extraction but does not prevent it. I understand the use of bone graft materials (including human bone, animal bone, and synthetic bone) with or without membranes of different natures (animal and synthetic). I understand the risk of infection following ridge preservation and membrane exposure which might require removal and replacement of the grant. I understand with ridge preservation, the healing of the extraction site will be slower which might extend the total time of treatment. I understand even with the ridge preservation procedure, I might need additional bone grafting or sinus lifting prior to implant placement.

Initials __________ Date ___________

8. **CROWNS, BRIDGES, VENEERS AND BONDING**
a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth, I further understand that I may be wearing a temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the final crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge or veneer (including shape, fit size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for final cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying final cementation.

Initials __________ Date ___________

b. I am electing to use high noble or ceramic instead of base metal in my crown and bridge restorations.

Initials __________ Date ____________

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

Initials __________ Date ____________

9. DENTURES – COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

Initials __________ Date ____________

10. ENDODONTIC TREATMENT (ROOT CANAL TREATMENT)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture in one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Initials __________ Date ____________

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease and preterm labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery and/or extractions. I understand the success of any treatment depend in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours following treatment. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contracted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Initials __________ Date __________

12. IMPLANTS

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity and this numbness may be of a temporary or rarely permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

Initials __________ Date ____________

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with each individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide Peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has known risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

Initials __________ Date ____________

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, dizziness and headache. I understand that nitrous oxide use in not indicated if I am pregnant.

Initials __________ Date ____________

I understand that dentistry in not an exact science and those therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Patient or Guardian Signature______________________________ Date______________

Doctor Name and Signature______________________________ Date______________

Treatment Coordinator Name and Signature: ______________________________ Date: ______________

ADULT HIPAA & INFORMED CONSENT

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
-Obtain payment from third-party payers; and/or
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy of Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used and/or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

INFORMED CONSENT

1. WORK TO BE DONE

I understand that both the dentists and dental assistants may treat me for the following dental procedures that may be necessary to provide dental treatment. I not only understand that I will be given explanation of performed treatments, but understand that the normal procedures for a first time patient may include a comprehensive or limited exam, radiographs (x-rays), fillings and fluoride application as necessary. However, this is subject to change depending on numerous factors including amount of future work needed and time.

In general terms the procedures you may need include: X-Ray, Cleaning, Deep Cleaning, Fillings, Crowns, Bridges, Extractions, Bone Graft, Impacted teeth removed, Root Canals, Full Denture, Partial Denture, Crown Lengthening, and/ or Implant.

2. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth discussed in my treatment plan.

And any other necessary treatment under paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

5. ANESTHESIA

I realize the risk involved in receiving local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reaction to drugs causing cardiac arrest, miscarriage, hemorrhage, never damage/numbness.

6. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I don't have the permanent crowns placed permanent serious damage or lost of the tooth/teeth involved ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

7. DENTURES-COMPLETE OR PARTIAL

I realize that full & partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change.

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that the root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I may have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions.

I hereby request and authorize the Dentists, and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, functions and the health of my mouth, teeth, bone and tissue, as explained above.

The effect and nature of the proceeding to be performed, and the risk involved, as well as possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistant to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of dentistry and surgery is not an exact science and that therefore, reputable practitioners can not properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have

herein requested and authorized.
Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage, and/or bleeding, scarring, contraction, possible deformity, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness and itching of the tongue, lip, teeth, tissue (Parasthesia), fractured jaw, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: ______________________________ Date: ____________

Patient or Legal Representative

Patient Name: ______________________________

LUNA Dental
Kids & Adults Dentistry

100 S. Americas Ave

El Paso, Tx. 79907

915-858-5862

Date: ______________________

As a convenience for you, our Billing Department is going to bill your Insurance Company for the services provided. If for any reason, your insurance does not cover any portion of our services you will be held responsible for the payment.

____

Signature

____

Parent/Guardian Signature (If Pt a minor)