

Have You Ever Had A Complication or A Reaction To Dental Anesthetics? Yes / No If Yes, Please Describe: _____

• Please List ALL Drugs and Medications You Are Taking (Both Prescription and Non- Prescription Drugs):

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician(s): _____ Phone: _____

_____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Internet School Work Other _____

Name of person or office referring you to our practice: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined handled before treatment begins.

I understand that the fee estimate listed for this dental care can only be extended for a period of 60 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. Photographs: I agree to allowing Kirk Hampton, DDS, and their agents to use the photographs of any portion of my dental treatment for the purpose of teaching, in publications related to dentistry, and any marketing or advertising media including but not to the Internet. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____