Dental History:

Date: ____________

Reason for Today's Visit ____________ Date of Last Dental Care ____________

Former Dentist ____________ Date of Last Dental X-rays ____________
Address ____________

Check (√) if you have or have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken fillings	☐ Sensitivity to Sweets
☐ Clicking or Popping Jaw	☐ Periodontal Treatment	☐ Sensitivity when Biting
☐ Food Collecting between the Teeth	☐ Sensitivity to Cold	☐ Sores or Growths in Your Mouth

How often do you floss? ____________ How often do you Brush? ____________

Medical History:

Physician's Name ____________ Date of Last Visit ____________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe: ____________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: ____________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (√) if you have or have had problems with any of the following:

☐ Anemia	☐ Congenital Heart Lesions	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hernia Repair	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Skin Rash
☐ Artificial Joints, Pins, etc...	☐ Cough up Blood	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Feet/Ankles
☐ Back Problems	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Bleeding Abnormally	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Disease	☐ Hemophobia	☐ Rheumatic Fever	☐

List of Medications you are currently taking: ____________

Allergies:

☐ Aspirin	☐ Local Anesthetic	☐ Iodine	☐ Other
☐ Barbiturates	☐ Penicillin	☐ Latex	
☐ Codeine	☐ Sulfa	☐ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____________ Signature of Patient, Parent, Guardian or Personal Representative ____________ Date

____________ Please Print Name of Patient, Parent, Guardian or Personal Representative ____________ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Release Form for Media Recording

I, the undersigned, do hereby consent and agree Dr Vivian J Hudson, DDS, its employees and/or agents have the right to take photographs, videotape or digital recordings of my mouth only beginning on ________________________. To use these in any and all media now or hereafter known, and exclusively for the purpose of marketing (including website). I further consent my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release Dr Vivian J Hudson, DDS, its agents and all employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims or interest I may have to control the use of my identity or likeness in whatever media used.

I understand there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand Dr Vivian J Hudson, DDS is not responsible for any expense or liability incurred because of my participation in the recordings, including medical expenses due to any sickness or injury incurred as a result.

I represent I am at least 18 years of age, have read and understand the foregoing statement and am competent to execute this agreement.

____

Name (please print) Relation to Patient

____

Signature of Patient Date

____

Witness (print name)

____

Witness signature Date

CONSENT FORM

Name: ______________________________ Phone Number: ______________________________

Address: ______________________________ City: ______________ State: ______ Zip: ________

Services preformed are due in full at the time of service unless prior written arrangements have been made.
Every reasonable effort will be made to inform you of the procedures to be performed and the fees for the services prior to starting your treatment. In the event it becomes necessary to alter the scheduled treatment, you will be advised before new treatment is started. It is important that you fully understand the need and nature of the treatment you are to receive.

INSURANCE ASSIGNMENT

This office accepts most Dental Insurance assignment of benefits. It is necessary for us to review, confirm coverage, and establish assignment of dental insurance benefits before accepting dental insurance payments for services rendered.

If time permits this office will assist the patient in obtaining a pre-estimate from your insurance company for services to be performed. It is the patient's responsibility to inform this office of the requirements of their insurance company regarding pre-estimates before treatment. If available to this office, an estimate of your dental insurance participation will be given prior to treatment. The estimated amount not covered by the insurance plan is due at the time of service.

If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the charges in full for the services rendered. The estimate rendered by this office is considered a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the 61st day after treatment, will be billed in full to the patient and become immediately due.

MISSED APPOINTMENTS

No charge will be made for rescheduling or canceling an appointment, but we ask that at least 24-hour notice is given. If a patient frequently reschedules or cancels appointments, we have the right to ask that said patient call the day of a needed appointment so that they can be worked into the schedule. Once an appointment has been made, please remember this time has been reserved specifically for you.

COLLECTION FEES

The patient or responsible party will pay cost incurred to enforce payment required by this agreement. Conducting treatment implies consent as outlined in this agreement.

FINANCIAL CONSENT

The Patient (Responsible Party) agrees to be fully responsible for total payments of services performed in this office, including any treatment not a benefit of any dental insurance the patient may have. I further authorize release of any information to the insurance company relating to treatment received in this office and payment directly to Vivian J. Hudson D.D.S. of the dental insurance benefits otherwise payable to me. I certify I have read, understand and agree to the conditions of this Agreement.

Responsible Party: ______________________________ Date: ______________

Insured Signature: ______________________________ Date: ______________

Doctor's Representative: ______________________________ Date: ______________