



Dr. James McLain

Today's Date: _____

Patient Name: _____
Last Name First Preferred Name

Address: _____

City: _____ State: _____ Zip: _____

Gender: MALE FEMALE Birth Date: _____

Family Status: MARRIED SINGLE CHILD OTHER

Phone Number: _____ Home Cell Work

Phone Number: _____ Home Cell Work

Social Security # _____ Drivers License # _____

Email Address: _____

Employer: _____

Employer's Address: _____
Phone

REFERRED BY: _____



ACCOUNT INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____
Last Name First Name

Address: _____

Phone: _____ Home Cell Work

In Event of Emergency, whom do we contact?

Name: _____ **Relationship:** _____

Phone #: _____

Who is your medical Doctor? _____

Medical Doctor Phone Number: (_____) _____



General Consent

Thank you for choosing our office for your dental care. We will work with you to help achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include relief of pain, the ability to chew properly and the confidence with social interaction that a pleasant smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw tenderness, or in predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does.

Please feel free to ask questions in regards to all dental procedures that are recommended to you.

Patient Signature or Parent/ Guardian Signature

Date



Appointment & Financial Policy

Please be aware that charges incurred for treatment provided are your responsibility regardless of any expected insurance coverage. Dental insurance is a benefit used to assist you with the cost of necessary dental expenses and should neither dictate nor prohibit treatment. As we work with you to reach your optimum oral health, **we require that your estimated co-payment for treatment be paid at the time treatment is rendered.**

As a courtesy to you, we will submit claims to your insurance on your behalf. However, it is important that you understand that the agreement regarding your dental insurance and dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, you are financially responsible for the services rendered in our office.

Downing Street Dental accepts payment in the form of cash, personal check, Discover, MasterCard, Visa and CareCredit. Returned checks will be subjected to bank fees and/or finance charges at the rate of 1.5% per month (18% annually).

We strive to keep all financial arrangements and accounts in house. However, account balances left unpaid for 90 days or more may be sent to a third party collection agency. You are responsible to pay all costs of collections including, but not limited to; collection fees, attorney fees, and interest.

Please keep in mind that we have reserved time in our schedule especially for you. We urge you to keep your appointments, due to limited time and space. **If you need to cancel or reschedule your appointment, please give us at least 48 hours notice**, so that we may offer your reserved time to another patient. **If we do not receive the required notice to cancel or reschedule an appointment, you will be charged a \$50.00 broken appointment fee.**

I have read, understand, and accept the terms and conditions of this policy.

Printed Name of Patient

Signature of Patient

Date

