

*Ronald R. Morin, DDS, FAGD*

Fellow, Academy of General Dentistry  
8619 Potranco Road San Antonio, TX 78251  
210-680-9980

DATE \_\_\_\_\_

**WELCOME!** We're glad you're here. Our goal is to deliver the highest quality restorative, cosmetic and preventive dental care available. We want to help you keep your teeth for a lifetime, and we look forward to getting to know you.

Please print:

**PATIENT INFORMATION:**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status:  Minor  Single  Married  Widowed  Separated  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Spouse's name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Physician's name \_\_\_\_\_ Date last medical visit \_\_\_\_\_  
If student, name of school/college \_\_\_\_\_  Full time  Part time  
Whom may we thank for referring you? \_\_\_\_\_  
What is the name you would like us to call you? \_\_\_\_\_

**DENTAL HISTORY:** Date of last dental visit \_\_\_\_\_

Are you having any discomfort right now? YES NO What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a bad experience in the dental office? YES NO

**ARE ANY OF YOUR TEETH SENSITIVE:**

To heat or cold? YES / NO Sweets? YES/ NO When biting or chewing? YES/ NO

**HAVE YOU NOTICED:**

Bleeding gums?	YES	NO
Bad breath or taste?	YES	NO
A family history of gum disease or tooth loss?	YES	NO
Frequent canker sores/cold sores/lesions?	YES	NO
Catching food in between teeth?	YES	NO
Any loose teeth?	YES	NO
A severely sore mouth?	YES	NO
A bite that feels uncomfortable or unusual?	YES	NO

**DO YOU:**

Clench or grind your teeth while awake or asleep?	YES	NO
Have difficulty opening your mouth?	YES	NO
Hear noises from the jaw joint?	YES	NO
Have a jaw that gets "stuck," "locked" or "goes out"?	YES	NO
Have pain in or about the ears or cheeks?	YES	NO

**HAVE YOU EVER:**

Had a serious injury to your jaw, head, or neck? YES NO  
Been treated for a temporomandibular disorder (TMJ/TMD)? YES NO If so, when, how, and by whom? \_\_\_\_\_

What are some questions about dentistry and oral health that you have never had adequately answered?

**What cosmetic procedures, if any, might you be interested in?**

Smile Design Bonding Veneers

Gum Recontouring Porcelain Crowns and Bridges Implants Inlays and Onlays Teeth Whitening



**ACCOUNT INFORMATION:**

Name of person responsible for your account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ Home phone \_\_\_\_\_ Cell#/Work # \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_  
Policy ID # \_\_\_\_\_ Insurance Phone # \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_

**FEES • PAYMENTS • INSURANCE**

Payment of fees and co-payments are due and payable at the time services are rendered unless financial arrangements have been made. A finance charge will be added to any balance over 90 days. . Please note that patients are responsible for all fees charged for services in our office, regardless if their insurance denies a claim or if they have exceeded their maximum benefits for their benefit year.

We accept cash, personal checks, money orders, VISA, MasterCard and Discover. A 5% courtesy discount is available for pre-paying dental treatment over \$500. We also offer outside interest-free financing plans for the funding of major cases. For major restorative or cosmetic appointments, a down payment is required.

**CANCELLATION/NO SHOWS:** As a courtesy to all patients, we require a 48-hour notice if you are unable to make your appointment. **A \$75 charge may be applied to your account per missed appointment, if sufficient notice is not received.**

**RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I have read all the insurance and financial policies described above. I agree to be responsible for payment of all services rendered on my behalf or on my dependents' behalf, regardless of what my insurance may do. I also understand that payment /co-payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2 % late charge (18% APR) may be added to my account. I further agree to assign any/all insurance benefits payable to me to the dental office of Dr. Ronald R. Morin. Should further information be needed in the course of my treatment, you have my permission to ask the respective health care provider or agency, who may release such information to you.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR)

\_\_\_\_\_  
DATE

**CONSENT FOR TREATMENT**

I hereby authorize Dr. Morin or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of Patient \_\_\_\_\_'s dental needs. Upon such diagnosis, I authorize Dr. Morin to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PARENT/RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT