



WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Name: _____ Date: _____

Dental Concerns

Check any of the following which you have at present or are concerned about:

- | | | |
|---|--|---|
| <input type="checkbox"/> Tooth Sensitivity | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food Impaction between Teeth |
| <input type="checkbox"/> Sore or Bleeding Gums | <input type="checkbox"/> Mouth Ulcerations | <input type="checkbox"/> Unpleasant experience from Dental Treatment |
| <input type="checkbox"/> Gums Puffy, Red, Swollen | <input type="checkbox"/> Teeth Clenching or Grinding | <input type="checkbox"/> Not Satisfied with Size, Shape, Color or Appearance of Teeth |
| <input type="checkbox"/> Loosening Teeth | <input type="checkbox"/> Clicking or Popping Jaws | <input type="checkbox"/> Other Concerns: _____ |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Missing Teeth | |
| <input type="checkbox"/> Biting inside of Cheek | <input type="checkbox"/> Play Contact Sports | |
| | <input type="checkbox"/> Sleep Apnea/Snoring | |

Cosmetic Smile Analysis

- Are your teeth straight? Yes No
If no, please explain: _____
- Are there spaces between your front teeth that you dislike? Yes No
- Are you satisfied with the color of your teeth? Yes No
If no, please explain: _____
- Are you satisfied with the shape of your teeth? Yes No
If no, please explain: _____
- Are any of your teeth chipped? Hidden? Protruding? Yes No
If yes, please explain: _____
- Do you have any jagged teeth or teeth that you think are too long or too short? Yes No
- Do you have old fillings or dental work that you think would look much better white? Yes No
- Are you satisfied with the way your teeth come together (bite)? Yes No
If no, please explain: _____
- What would you most like to change about the appearance of your teeth? _____
- How would you like your teeth to look? _____

Please return your evaluation to us. We'd like to review your responses and together determine the best treatment options available to create the beautiful and confident smile you envision and deserve.

Raul S. Saenz II, DDS, PA
2200 Space Park Dr, Ste 208 Houston TX 77058
281 335 5577

FINANCIAL POLICY

We appreciate you choosing our office to provide your dental care. We value our relationship with your family and would like to offer the following as our payment policy.

You are responsible for charges associated with each of the services you receive during the course of your treatment. Payment is due on the day you receive services. After your exam, we are happy to provide you with a treatment plan that includes each dental procedure recommended and the fees. Once the treatment plan and estimated insurance benefits are reviewed with you, we require that you pay your portion in full at the time of service. If you do not have insurance, or the treatment you have is not covered by your insurance policy, the entire amount of your bill will be due before your procedure on the day of your appointment.

Payment Options

For your convenience we accept **Visa, MasterCard, Discover, American Express cash and personal checks** in our office. We also have patient payment plans available through **CareCredit** outside financing sources.

Insurance

If you have insurance, we will be happy to file a claim with your insurance company on your behalf. However, please realize that the relationship is between you, the insured, and your insurance company. We do not guarantee the final payment amount from your insurance company. You remain legally fully responsible for the entire bill. Once the treatment plan and estimated insurance benefits are reviewed with you, we require that you pay your estimated portion in full at the time of service. Please remember this is only an estimate. While we are here to assist you with your insurance, it is your responsibility to know what is covered and what is excluded from your dental plan.

If you have any questions regarding your insurance benefits, please don't hesitate to call our office at 281-335-5577 to review your concerns.

Print name

Signature

Date

Perfection is a just smile away...

Raul Saenz II, DDS, PA

Acknowledgement of Cancellation Policy

We respect our patients' time, and do not double-book patients as some offices do. Instead we reserve each time slot to one patient. If a patient is late for an appointment it may be almost impossible to see such a patient without setting back the schedule for the rest of the day. If we can accommodate a very late patient, we do. However, you will agree that it is extremely unfair to keep every remaining patient waiting in order to accommodate a very late patient. Our cancellation policy is very reasonable. If a patient does not show for an appointment or cancels an appointment late, we assess a \$25 fee for appointments an hour or less, and \$50 for appointments over an hour. Late cancellation means within 48 hours before appointment or after closing hours at 12:00 pm Friday for Monday appointments.

I hereby understand that I am responsible for keeping the appointment time allotted to me unless I give notice at least 48 hours before the appointment time or before closing hours at 12:00 pm Friday for Monday appointments. If I am unable to keep my appointment within this time period I understand that a cancellation fee applies.

Name

___/___/___
Date