
DENTAL HISTORY AND CONSENT FOR TREATMENT

Reason for seeking dental care at this time _____

Date of last dental visit _____ Reason? _____ Date of last X-rays _____

Former dentist _____ City/state _____

How often do you: **Brush** _____ times per _____ **Floss** _____ times per _____

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Aching or sensitive teeth | <input type="checkbox"/> Broken filling | <input type="checkbox"/> Areas of food traps | <input type="checkbox"/> Unfavorable dental experience |
| <input type="checkbox"/> Sensitive or bleeding gums | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Difficulty opening wide | <input type="checkbox"/> Growths or lesions in your mouth |
| <input type="checkbox"/> Broken or missing teeth | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Clicking or popping in jaw | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Grinding or clenching | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Gum infection | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Other _____ |

If you could change your smile, what would you change?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Remove unsightly fillings | <input type="checkbox"/> Straighten teeth | <input type="checkbox"/> Change shape of teeth | <input type="checkbox"/> Close gaps between teeth |
| <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Whitening | <input type="checkbox"/> Make teeth same color | <input type="checkbox"/> Other _____ |

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of patient or
authorized responsible party

Relationship

Date

Primary insurance

Insured's name _____
Insurance company _____
Address _____

Phone _____
Union or Local # _____
Group _____
Employer _____
Social Security # _____

Secondary insurance

Insured's name _____
Insurance company _____
Address _____

Phone _____
Union or Local # _____
Group _____
Employer _____
Social Security # _____

Insurance agreement

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

Signature of responsible party

Date