

Dental History

Are you in dental discomfort? _____

Reason for visit today _____

Date of last dental care ___/___/____ Date of last X-ray ___/___/____

Former dentist _____

Have you had any unfavorable dental experiences? _____

Check if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? _____

How often do you floss? _____

Have you ever had instruction on the correct method of brushing teeth? ___ Yes ___ No

Have you ever had instruction on the care of your gums? ___ Yes ___ No

How do you feel about the appearance of your teeth and smile?

What would you like to change? _____

Please read through the following sections. The section titled FINANCIAL POLICY and AUTHORIZATION both require the signature of the person responsible for the account. If you have any questions or concerns, please feel free to ask.

MINOR/CHILD CONSENT

I, being the parent of _____ do hereby request and authorize the dental team to perform necessary dental services for my child, including but not limited to, X-rays and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I agree to be responsible for payment of all such services.

Signature of Responsible Party _____ **Date** ___/___/___

FINANCIAL POLICY (Please read the following statement and initial / sign where indicated.)

Patients are expected to pay in cash, check , or credit card the day the service is rendered. I understand that I will be charged for failed appointments and appointments canceled without 24 hours notice. **Initial** _____

For those patients of record who are covered by insurance, we will accept assignment of benefits. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this and the extreme delay in receiving payment from the insurance company, we ask that you pay your deductible and co-payment, the day the service is rendered. We will estimate as closely as possible using the insurance information that we have, however this is an estimate. We will assist you in working with your insurance company, however, the ultimate responsibility lies with you. After sixty (60) days the balance will be due in full. **Initial** _____

I agree to be responsible for payment of all services rendered on my behalf or my dependents, and that payment is due at the time of treatment. I understand that a 1.5% finance charge will be added to my account for charges due over sixty (60) days.

Signature _____ **Date** ___/___/___

AUTHORIZATION (Please read the following statement and sign where indicated.)

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for the services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature _____ **Date** ___/___/___