

- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes _____ No _____
If yes, please explain: _____
- Do you use any tobacco products? Yes _____ No _____ How long? _____ How much _____
- Do you experience difficulty when swallowing? Yes _____ No _____

Dental History

Purpose of this dental visit _____

Date of last dental examination: _____ Date of last x-rays: _____

Are you having pain or discomfort at this time? Yes _____ No _____

Do you feel very nervous about having dental treatment? Yes _____ No _____

Have you ever had a bad experience in a dental office? Yes _____ No _____

Are there now any growths or sores in or around your mouth? Yes _____ No _____

Do you have any trouble chewing? Yes _____ No _____

Does food catch between your teeth? Yes _____ No _____

Do you have pain in or near your ears? Yes _____ No _____

Do you habitually clench or grind your teeth during the day or night? Yes _____ No _____

Have you ever been told you have gum problems? Yes _____ No _____

Do you now have bleeding gums or any other gum condition? Yes _____ No _____

Do you like the color of your teeth? Yes _____ No _____

Would you like it, if we could, straighten your teeth without braces? Yes _____ No _____

Do you have spaces you do not like? Yes _____ No _____

If yes, please explain _____

Do you like the shape of your teeth? Yes _____ No _____

If no, please explain _____

Are there old fillings or dental work that you don't like looking at? Yes _____ No _____

If yes, explain _____

What would you like to change the most in the appearance of your teeth? _____

If you have insurance, please present a card or completed form to one of our staff at the front desk

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENT

TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION ON BOTH SIDES OF THIS FORM IS TRUE AND CORRECT. IF THERE IS ANY CHANGE IN MY HEALTH OR MY MEDICATIONS, I WILL INFORM THE DOCTOR PRIOR TO ANY TREATMENT.

I AUTHORIZE THE DOCTORS AND/OR THEIR STAFF TO TREAT THE ABOVE NAMED PATIENT. I WILL CONTACT THE DOCTOR'S OFFICE IF I HAVE ANY ADDITIONAL QUESTIONS OR THERE ARE ANY UNEXPECTED REACTIONS TO TREATMENT. I REALIZE THAT THE RESULTS OF CERTAIN PROCEDURES CANNOT BE GUARANTEED.

ALL FINANCIAL ARRANGEMENTS WILL BE MADE PRIOR TO TREATMENT. I REALIZE THAT, ULTIMATELY, I AM COMPLETELY RESPONSIBLE FOR PAYMENT OF ALL TREATMENT. THE OFFICE WILL ASSIST BY FILING ALL NECESSARY INSURANCE PAPERWORK.

I REALIZE THAT THE FEE ESTIMATE LISTED FOR DENTAL CARE IS VALID FOR ONLY SIX MONTHS.

I HAVE READ AND FULLY UNDERSTAND THE CONDITIONS OF TREATMENT AS STATED.

SIGNATURE: _____
_ DATE: _____

I have reviewed my medical history and the above (including any changes) is accurate:

Date: _____	Initials: _____	Date: _____	Initials: _____
Date: _____	Initials: _____	Date: _____	Initials: _____
Date: _____	Initials: _____	Date: _____	Initials: _____