DENTAL INFORMATION HISTORY

Patient's Name______________________________ Chief Dental or Oral Complaint______________________

Date of last Dental Appointment____________ ___Dentist Name______________________ City__________________ State__________

Are your teeth sensitive to:	YES	NO
Heat?	___	___
Cold?	___	___
Sweets?	___	___
Biting Pressure?	___	___
Does food catch between your teeth?	___	___
Do you have an unpleasant taste or odor in your mouth?	___	___
Do you have any lumps or swelling in your gum tissue or mouth?	___	___
Do you clinch or grind your teeth?	___	___
Do you hear any clicking or snapping when chewing?	___	___
Do you have any oral habits, such as: Fingernail or cheek biting, thumb/finger sucking, etc?	___	___
Do you smoke or chew tobacco?	___	___
Have you had any injury to your mouth teeth, face or jaw? If YES, please explain:	___	___

____

Have you had your wisdom teeth extracted:
_____ All _____ Some _____ None _____ Not Sure

	YES	NO
Have you had any other adult teeth removed? If YES, how long have these teeth been missing?	___	___

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	YES	NO
Have you ever had any complications from an extraction or Dental treatment? If YES, please explain:	___	___

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	YES	NO
Do you have any Dental fears? If YES, please explain:	___	___

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	YES	NO
Do you ever avoid any part of your mouth when brushing?	___	___
Do your gums bleed when brushing?	___	___

	YES	NO
Have you ever had any Periodontal (Gum) treatment or Surgery? If YES, Dentist name & date:	___	___

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	YES	NO
Have you ever had braces or any other type of Orthodontic treatment? If YES, Dentist & date:	___	___

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Do you use any of the following dental hygience aids?	YES	NO
Oral Irrigating device (Water Pik, etc.)	___	___
Electric toothbrush or similar appliance	___	___
Flossing aids	___	___
Mouthwashes or Oral rinses	___	___
If YES, what brand____________________		
Flouride supplement	___	___
If YES, type & brand ____________________		
Is your drinking water fluoridated? Not sure___	___	___
Are you deeply concerned about the finances required to return your mouth to excellent Dental health?	___	___
Are you frustrated because you always need something to be treated or repaired when you visit a Dentist?	___	___
Do you feel you will eventually wear artificial dentures?	___	___
Do you have any dental implants?	___	___
Have you ever had your teeth whitened or bleached?	___	___
Do you like your SMILE?	___	___

What would you like to change about your teeth or smile if you could? ____________________

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How would you rate your overall Dental health?
____Good ____Fair ____Poor

How many times a day do you brush yoru teeth? ________

How many times a week do ou floss your teeth? ________

APPOINTMENTS – A minimum charge will be made for failed or canceled appointments without prior notification of at least 24 hours. In fairness to all of our patients, advance notice is needed to change an appointment.

INSURANCE – For your convenience, we will complete any forms required by your dental insurance company. Your signature below authorizes the release of any information regarding your dental claims to your insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost, if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay all our charges. Each fee is individual for the individual patient.

PAYMENT – Payment is expected when services are rendered, unless other arrangements are made in advance. A service charge of 1.5% per month (equivalent to 18% PER ANNUM), will be added to the unpaid balance of all accounts over 60 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses, including all court costs and reasonable attorney's fees.

Consent – To the best of my knowledge, all of the preceding answers are correct. If I have any change in my health, or if my medications change, I will inform this office at the next appointment without fail. I hereby consent to allow diagnosis, proper dental care and treatment to be performed by this practice for myself or the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature______________________________ **Date**____________________

(Parent or Guardian, if Patient is a minor)