DENTAL HISTORY AND CONSENT FORM

What is your estimation of your dental health**?** Excellent Good Fair Poor

Is your mouth comfortable now? Yes No

If no, please describe the discomfort or problem:
_____
_____

Do you have any active dental disease in your mouth that you are aware of? Yes No

When did you last see a dentist and for that?
_____

Name of your last dentist and city and state located in?
_____

Are you satisfied with the appearance of your teeth? Yes No

If no, please describe what you would like changed:
_____
_____

Have you had any serious trouble with a previous dental experience? Please specify:
_____
_____

Please list any other comments regarding your teeth, mouth ,TMJ or dental history:
_____
_____
_____

CHILDREN: Check all that apply

Have fluoridated water? yes no
Does child take fluoride supplements? yes no
Any oral habits like finger or thumb sucking? yes no
Any difficulty with previous dental visits? yes no
Please list any other pertinent information or concerns:

CONSENT

I ***authorize*** doctor to take any necessary xrays,photographs and study models deemed necessary to make a thorough diagnosis and ok the release of the dental records to individuals involved in my dental care.
Upon diagnosis, I ***authorize*** doctor to perform all recommended treatment mutually agreed upon by me.
I ***consent*** to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk
I ***authorize*** insurance payments to be made directly to Dr Johnson. I understand that I am responsible for any unpaid balance
I *am aware* that should I not provide 48 hour notice to change an appointment, I may be charged a fee
I ***authorize*** the office of Dr Johnson to confirm my appointments through reminder cards sent in mail and by telephone call

Patient Signature_____**Date**_____

Parent or Guardian(if patient is a Minor)_____**Date**_____