Patient's Dental Health

Why have your come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last visit _____ Date of last cleaning _____

Reasons for changing dentists _____

Have you had any problem with past dental treatment? _____

Are you nervous about seeing a dentist? € No € Yes If Yes, please tell us why _____

How often do you brush? _____ Do you floss? € No € Yes How often? _____

Please circle each

Y N	I have problems eating.	Y N	Do you have black Mercury fillings that show or concern that you would like to be changed?
Y N	I have had orthodontics.	Y N	Do you have any old crowns or caps that don't match your natural teeth or that you unhappy with?
Y N	Have you had a facial or jaw injury?	Y N	Do your gums bleed while brushing or flossing?
Y N	Do you want your teeth straighter?	Y N	Do your gums feel tender or swollen?
Y N	Do you clench or grind your teeth during the day or while sleeping?	Y N	Do you gums that have pulled away from your teeth?
Y N	I prefer white filling (composite)	Y N	Do you have bad breath?
Y N	I want my teeth whiter in 1-hour	Y N	Y N Do you have a change in the fit of partial dentures?
Y N	Do you like your smile? Why? _____.	Y N	Others: _____.

Emergency contact information

In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

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How did you hear about our office?

€ Yellow pages € Insurance plan € Newspaper Ad € Direct mailing € Internet € Sign by building € TV/Radio Ad

€ Referred by a friend € Relative - Please let us know whom to say thank to _____

€ Other _____

Consent

I will answer all health questions to the best of my knowledge. _____ Date _____

Patient's Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate In order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Financial Arrangements

- Payment is expected to be paid in full when services are performed unless other arrangements are made in advance. We accept **Cash, Check, VISA, Master**, and **Discovery** cards
- Returned checks will be charged an additional fee of $50.00. Any unpaid balances (older than 30 days) will incur a 1.75% finance charge per month and additional collection fee if Applicable
- The dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We are as dental care providers and our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to your patients, all charges are your responsibility from the date the services are rendered.
- The patient's co-pay and insurance coverage portion is only an estimate that bases upon your dental insurance information given at the time of verification. You will assume responsibility for any residual balance(s) or unpaid portion(s) by your insurance.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records and any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioner. I authorize and request my insurance company to pay directly to the doctor or medical group insurance benefits otherwise payable to me. I understand that my health insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Relationship _____ Date _____

Signature of patient (or parent/guardian if minor)