

Information Update/Consent for Treatment

Insured Party Information (Primary Card Holder)

Name _____ Gender _____

Address _____ City _____ State _____ Zip _____

Home Number _____ Work Number _____ DL _____

SS Number _____ Birthdate _____ Relationship _____

Employer _____ Yrs _____

Spouse/Dependent Information

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Yrs _____

Work Number _____

Please Check All Dental Conditions That Apply To You

- | | |
|---|---|
| <input type="checkbox"/> Trouble from previous dental care | <input type="checkbox"/> Pain in jaw or near ears |
| <input type="checkbox"/> Unhealed injuries/inflamed area around mouth | <input type="checkbox"/> Swelling/Lumps in mouth |
| <input type="checkbox"/> Novocaine or other | <input type="checkbox"/> Nitrous Oxide (laughing gas) |
| <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> loose tooth |
| <input type="checkbox"/> Reaction to any anesthesia | <input type="checkbox"/> Difficult Extractions |
| <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Gums Bleed |
| <input type="checkbox"/> Bad taste/mouth odor | <input type="checkbox"/> Chew on one side |
| <input type="checkbox"/> Instructions on care of gums | <input type="checkbox"/> Jaw Clicking or Popping |
| <input type="checkbox"/> Food caught between teeth | <input type="checkbox"/> Clench/Grinding of teeth |
| <input type="checkbox"/> Sensitivity to hot/cold sweets/air | |

I hereby authorize doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I also authorize doctor to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I further authorize the release of information, including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility for payment for dental services provided in this office for my dependents or me is mine, due and payable at the time services are rendered.

Signature of Patient or Responsible Party _____ **Date** _____