Dental history and consent for treatment

Reason for seeking dental care at this time _____

Former dentist _____ City/state _____

Date of last dental visit _____

Reason? _____ Date of last X-rays _____

How often do you: Brush _____ times per _____ Floss _____ times per _____

How do you feel about dental treatment?

- ☐ Relaxed
- ☐ A little uneasy
- ☐ Tense
- ☐ Anxious
- ☐ Very anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

- ☐ Aching or sensitive teeth _____
- ☐ Broken filling _____
- ☐ Areas of food traps _____
- ☐ Unfavorable dental experience _____
- ☐ Sensitive or bleeding gums _____
- ☐ Loose teeth _____
- ☐ Difficulty opening wide _____
- ☐ Growths or lesions in your mouth _____
- ☐ Broken or missing teeth _____
- ☐ Bad breath _____
- ☐ Clicking or popping jaw _____
- ☐ Cold sores _____
- ☐ Grinding or clenching _____
- ☐ Swollen glands _____
- ☐ Jaw pain or tiredness _____
- ☐ Dry mouth _____
- ☐ Swelling or lumps in mouth _____
- ☐ Gum infection _____
- ☐ Orthodontic treatment _____
- ☐ Other _____

If you could change your smile, what would you change?

- ☐ Remove unsightly fillings
- ☐ Straighten teeth
- ☐ Change shape of teeth
- ☐ Close gaps in teeth
- ☐ Replace missing teeth
- ☐ Whitening
- ☐ Make teeth same color
- ☐ Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____ Date _____

Patient signature/legally authorized representative

_____ Relationship _____

Printed name if signed on behalf of the patient

Primary insurance

Insured's name _____

Insurance company _____

Address _____

Union or local number _____

Group _____

Employer _____

Social Security number _____

Secondary insurance

Insured's name _____

Insurance company _____

Address _____

Union or local number _____

Group _____

Employer _____

Social Security number _____

Insurance agreement

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and me. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand that my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

_____ Date _____

Patient signature/legally authorized representative