PATIENT NAME _____ **DATE** _____

WELCOME!

So that we may provide you with the best possible care please complete both sides of this medical/dental history form.
All information is completely confidential.

How can we help you today? _____

How often do you have dental examinations? _____

Date of Last Dental Appointment: _____ **Last Complete Series of Radiographs:** _____

How often do you brush your teeth? _____ How often do you floss?_____

Do you have any dental problems right now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot, Cold, Sweets, Biting, or Chewing?	Yes	No
Do you frequently get cold sores,	Yes	No
Do your gums ever bleed or hurt?	Yes	No
Have you ever had Periodontal Treatment?	Yes	No
Have you experienced:		
Clenching or grinding of your teeth while awake or asleep?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
A bite plate or mouth guard?	Yes	No
Difficulty in opening or closing?	Yes	No
Difficulty in chewing?	Yes	No
Tired jaws, especially in the morning?	Yes	No
Headaches or sore muscles?	Yes	No

Your Physician's name: _____
Address/Phone: _____
When was your last complete medical physical?_____

Have you ever had:		
Orthodontic Treatment?	Yes	No
Oral surgery?	Yes	No
Are you satisfied with the appearance of your teeth?	Yes	No
Do you feel nervous about dental treatment?	Yes	No

If so, what is your biggest concern? _____
_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please talk to your provider about the experience.

Have you ever been diagnosed with osteopenia or osteoporosis?	Yes	No

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CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this for myself or my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made.
24hr. Cancellation Notice required or fee will be assessed.

Patient/Parent/Guardian Signature: _____ SS#: _____

Please provide us with your social security number if you would like us to file insurance claims on your behalf.