DENTAL INFORMATION

1. Are you experiencing pain or any problem with your mouth at this time? .... Yes No
2. When was your last dental examination? ______________________
3. Frequency of dental care. __________ Regular __________ Periodic __________ Emergency
4. Have you lost any teeth? Reason. ______________________ Yes No
5. Have you had extensive dental work performed in your mouth? (Crowns, bridges, partials, etc.) .... Yes No
6. Did your parents keep their teeth? ______________________ Yes No
   If not, how old were they when they lost their teeth? ______ Mother ______ Father
7. Have you in the past ever had periodontal (gum) therapy? If yes, when and by whom ______________________ Yes No
8. Do your gums bleed? .... Yes No
9. Have you noticed any loose teeth? If yes, how long ______________________ Yes No
10. Do you have any sensitive teeth? .... Yes No
11. Have you had a toothache recently? .... Yes No
12. Have you ever had cold sores in your mouth? .... Yes No
13. Does your jaw click when you chew? .... Yes No
14. Are you aware of clenching or grinding your teeth? .... Yes No
15. Have you ever had an injury to your face or jaws? .... Yes No
16. Do you think your teeth are affecting your general health in any way? .... Yes No
17. Are you satisfied with the appearance of your teeth? .... Yes No
18. Based on what your dentist has told you, how would you rate the condition of your mouth on a scale of 1 to 10 where 1 is severe and 10 is optimal health? ______________________
19. Please list any other pertinent dental information. ______________________

CONSENT

1. I hereby authorize doctor or designated staff (with my consent) to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of name of patient) ______________________'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf.

I understand that payment is due at the time of service unless other arrangements have been made.

A 48 hour notice is requested for all appointments, with the exception of surgical procedures, which require a weeks notice.

Note: A fee may be charged for broken appointments.

Patient ______________________ Date __________ Witness ______________________