

PATIENT HEALTH INFORMATION (Continued)

When was your last dental visit? _____ What was done then? _____
 How often did you visit the dentist before then? _____
 Previous dentist (name and location) _____
 Have you had a complete series of x-rays taken? When _____ Where _____
 How often do you brush your teeth? _____ How often do you floss your teeth? _____

	YES	NO
Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour foods/liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Have you ever experienced any of the following problems in your jaw?		
Clicking	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>

Reason for today's office visit _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge, and all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any records of treatment and x-rays to other health practitioners or insurance companies. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that, when appropriate, Credit Bureau reports may be obtained. In order to avoid an appointment cancellation fee, I agree to give at least 24 hours advance notice.

Signature of patient (or parent if minor) _____

Date _____