Name: _____

Reason for seeking dental care at this time? _____

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

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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	☐ Negative Dental Exp.
☐ Sensitive or bleeding gums	☐ Loose Teeth	☐ Difficulty opening wide	☐ Growths or lesions
☐ 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
☐ 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 that 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.

Signature of patient _____ Date: _____