PATIENT DENTAL HISTORY

HOW LONG since you have seen a Dentist? _____

Is your present dental health ☐ GOOD ☐ FAIR ☐ POOR

	YES	NO
Are you having PROBLEMS now?	☐	☐
Are you AFRAID OR NERVOUS about dental treatment?	☐	☐
Do your gums BLEED, feel TENDER or IRRITATED?	☐	☐
Are you teeth SENSITIVE to hot, cold, sweets, pressure?	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES or NECK PAINS?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

How do you feel about your teeth? _____

FINANCIAL POLICIES

1.) **RESPONSIBLE PARTY**- The parent/guardian who presents a **minor child** for treatment is responsible for payment of the account, regardless of any court orders stating otherwise, unless **written** permission to bill another party is presented to our office at the time of service.

2.) **COLLECTION COSTS**- I agree to pay any **attorney fees, court costs** and a **35%** Collection Fee if collection by a third party is necessary.

3.) **BAD CHECK CHARGE**- I understand that a **$25** charge will be added to my balance if any check is returned for insufficient funds.

4.) **MISSED APPOINTMENTS**- I understand there may be a **$35** charge for missed appointments without 24 hour notification.

The information I have given today is correct to the best of my knowledge. It is my responsibility to **inform** this office of any changes in medical status. I authorize the dental staff to **perform any necessary dental services** with my informed consent that may be needed during diagnosis and treatment. I authorize **release of any information** including the diagnosis and records of any treatment rendered to me or my child to **insurance companies or health practitioners**. I authorize and request my insurance company to **pay directly to the dentist** benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to pay any amount not covered. I understand the **Financial Policies** and agree to be **responsible for payment** of all services rendered to me or my dependents.

SIGNITURE OF PATIENT or RESPONSIBLE PARTY:

_____ **DATE:** _____