DENTAL HISTORY

ARE ANY OF YOUR TEETH SENSITIVE?	YES	NO
DO YOU CLENCH OR GRIND YOUR TEETH?	YES	NO
DO YOU SNORE?	YES	NO
DO YOUR GUMS BLEED?	YES	NO
HAVE YOU EXPERIENCED CLICKING, POPPING OR TENDERNESS IN YOUR JAW?	YES	NO
HAVE YOU EVER HAD BRACES, GUM TREATMENT, A BITE PLATE OR MOUTHGUARD?	YES	NO
ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?	YES	NO

WHAT WOULD YOU CHANGE ABOUT YOUR SMILE?

_____

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT?	YES	NO

IF SO, WHAT IS YOUR BIGGEST CONCERN?

_____

WHAT IS YOUR CHIEF DENTAL COMPLAINT?

_____

COMMENTS ABOUT PREVIOUS DENTAL TREATMENT:

_____

CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis, I authorize the 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. If necessary, appropriate financial arrangements will be coordinated and monitored by the office manager. Any questions or change pertaining to financial arrangements must be approved by the office manager and/or the doctor.

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PARENT OR RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED AND/OR REVIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.
A copy is available upon request

_____ _____

SIGNATURE ***YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*** **DATE**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: