Medical History (Continued)

If you are taking any medications, including herbal supplements, please list them and the daily dosage

_____

_____

Are you under the care of a physician?_____ For what condition?_____
Are you pregnant? _____
Is there any other information we should know about your medical health? _____

_____

_____

Dental Information

Reasons for today's visit? _____

When was your last dental visit and what treatment was done? _____

_____

What was the reason for leaving your previous dental office? _____

_____

How often do you brush your teeth?_____ Floss your teeth? _____

	YES	NO
Do your gums bleed while brushing or flossing?	____	____
Do your gums feel tender or swollen?	____	____
Are your teeth sensitive to:	____	____
hot foods or liquids	____	____
sweets	____	____
cold foods or liquids	____	____
Do you like the color of your teeth?	____	____
Are you confident about smiling in front of other people?	____	____
Are you satisfied with the appearance of your teeth and smile?	____	____
Are there any unsightly fillings you would like to change?	____	____
Do you clench or grind your teeth while sleeping or during the day?	____	____
Do your jaws or facial muscles often feel tired or sore?	____	____
Do you have headaches or earaches when you wake in the morning?	____	____
Do you think your teeth are excessively worn, chipped, or cracked?	____	____
Do you think your teeth are in good alignment (straight)?	____	____

If you could change anything about your smile, what would it be? _____

_____

Is there anything else that you would like us to know about your dental health? _____

_____

The above information is accurate and true to the best of my knowledge and is for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I understand that I am fully responsible for the total cost of my treatment regardless of any insurance payments. I will not hold my dentist or any other member of his/her dental staff responsible for any errors or omissions that I may have made in the completion of this form.

WE REQUIRE 48 HOURS NOTICE IF YOU MUST CHANGE AN APPOINTMENT OR A FEE WILL BE CHARGED TO YOUR ACCOUNT.

Date_____ Signature _____

If applicable: If you think there will be any extensive dental treatment to be performed, would you be interested in any of the following financial options.

_____Payment in full at the beginning of treatment with a 5% reduction for any procedure over $700.00. Must be paid with check or cash only.
_____Payment with cash, check, Visa or MasterCard
_____Payment with three post dated checks for three consecutive months or pre-authorized payments for three credit credit card payments for three consecutive months