

DENTAL HISTORY

Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist.

- Is there a dental problem you would like treated immediately? Yes Problem: _____ No **YES NO**
- Are there any other dental conditions that concern you at present? Yes Condition: _____ No
- Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____
1. Have you been seeing a dentist regularly? _____
 2. Have you ever had any of the following? (please circle)
 - Periodontal Treatment? (treatment of the gums) _____
 - Orthodontic Treatment? (to straighten or realign teeth) _____
 - A bite plate, night guard or any other appliance? _____
 - Crowns or Bridges? _____
 - Dentures or Partial Dentures? (circle) _____
 - Wisdom Teeth Removal? _____
 - Root Canal Treatment? _____
 3. Are there any growths or sore spots in your mouth? _____
 4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____
 5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____
 6. Does food catch between your teeth? _____
 7. Are any of your teeth sensitive to heat, cold, sweets or pressure? (circle) _____
 8. Have you ever experienced any of the following jaw problems:
 - Popping/clicking in your jaw joints? _____
 - Pain in your jaw joints, around your ear, or side of your face? _____
 - Difficulty in opening or closing? _____
 - Pain when teeth are clenched? _____
 - Pain or difficulty while chewing? _____
 9. Do you have any of the following habits?
 - Clenching or grinding your teeth while awake or asleep? _____
 - Biting your cheeks or lips? _____
 - Mouth breathing while awake or asleep? _____
 - Gag reflex: slight _____ moderate _____ severe _____
 10. Are you missing any teeth? Yes No If so, have they been replaced? Yes No If not, would you like them replaced? Yes No
 11. Are you unhappy with the appearance of your teeth? _____
and, What would you like to see changed? _____
 12. Do you have any concerns about halitosis (bad breath)? _____
 13. Are you interested in any of the following? (Please ✓)
 - Teeth whitening or bleaching Cosmetic dentistry
 - Treatment of bad breath (halitosis)
 - Orthodontic treatment
 14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____
15. Please place a mark on the line below indicating the degree of anxiousness you experience when having dental work done.
- Not anxious at all _____ Greatest amount of anxiety imaginable

OFFICE POLICY

APPOINTMENTS

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore at least 24 HOURS NOTICE **MUST** be given if cancellation is absolutely necessary.

PAYMENT OF FEES

1. Payment is required on the day of your appointment unless other financial arrangements have been made.
2. We will assist you in the processing of your insurance forms.
3. We can help you with alternate methods of financing if required.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information.

I consent to the collection, use or disclosure of personal information as required for my own or my dependants dental care.

CONSENT

I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____