CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
   (Name of Patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed upon dates I understand that a 1-1/2% late charge 18% APR) may be added to my account.

5. I hereby authorize payment directly to below-named dentist of the group insurance benefits otherwise payable to me.

PATIENT_____DATE _____ WITNESS _____

PARENT OR RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT _____

DR. SIGNATURE _____ DATE _____

We'd like to get to know you better!

Name.....

Address.....

City..... State.....ZIP.....

Home Phone #.....

(Cell Phone) .....

Occupation.....

Employer.....

Social Security Number.....

Employer Address.....

..... Phone.....

Date of Birth.....

Marital Status .....

Spouse's Name.....

Spouse's Employer.....

Address.....

..... Phone.....

Spouse's Social Security #.....

Who referred you to this office?.....

.....

Person responsible for dental investment?.....

.....

Dental History

	Yes	No
Are your teeth sensitive to heat?	☐	☐
cold?	☐	☐
sweets?	☐	☐
biting pressure?	☐	☐
Do you clench or grind your teeth	☐	☐
Do any teeth feel loose?	☐	☐
Do you have any food traps?	☐	☐
Have you noticed any gum swelling?	☐	☐

	Yes	No
Do your gums bleed when brushing	☐	☐
Have you had any previous injuries to the face or jaw?	☐	☐
Have your gums ever been treated?	☐	☐
Have you ever had your bite adjusted	☐	☐
Have you ever experienced problems with novacaine?	☐	☐

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Dental Profile

	Yes	No
Have you had a complete dental exam, including x-rays within the past three years?	☐	☐
Have you had your teeth cleaned regularly	☐	☐
How often.....		
Have missing teeth been replaced?	☐	☐
If so, how long ago?.....		
Would you like to keep your natural teeth?	☐	☐
Have you been instructed regarding proper home care?	☐	☐
Do you know what periodontal disease is?	☐	☐

When was your last dental examination.....

.....

What is the purpose of your office visit today?.....

.....

.....

Dental/Medical History

	Yes	No
Do you have any general health problems?	☐	☐

If so, please specify.....

.....

Are you currently under a doctor's care?	☐	☐

Reason.....

	Yes	No
Have you been hospitalized in the past two years?	☐	☐
Have you had x-ray therapy in the past year for tumors or cancer?	☐	☐
Do you currently take drugs or medication	☐	☐

Please list:.....

Are you currently taking Bisphosphonates?	☐	☐
Have you had any orthopedic total joint replacement? Date What Have you had any complications	☐	☐

To the best of your knowledge, are you or have you ever been afflicted with:

	Yes	No
Heart ailment?	☐	☐
Mitro Valve Prolapse?	☐	☐
Rheumatic Fever?	☐	☐
Diabetes?	☐	☐
Epilepsy?	☐	☐
High Blood Pressure?	☐	☐
Respiratory Disease?	☐	☐
Fainting spells?	☐	☐
Prolonged bleeding?	☐	☐
Healing complications?	☐	☐
Ear problems?	☐	☐
Nervous or mental problems?	☐	☐
AIDS?	☐	☐
HIV positive?	☐	☐
Hepatitis?	☐	☐
Allergic to any medications?	☐	☐

If so, which ones?.....

.....

Do you use tobacco?	☐	☐

Name of physician.....

Date of last physical.....

Are you pregnant?	☐	☐

Date of delivery?.....

Comments.....

The above information is true and correct to the best of My knowledge.

.....

Patient Signature Date

.....

Dr. Signature Date