How often do you Brush? ________ Floss? ________ Use a waterpik? ________ Use a toothpick? ________
Proxy brush? __________ Perio Aid? ___________ Other dental devices? ___________________

Do your gums bleed when you brush or floss?	Yes	No
Do you have any swelling or lumps in your mouth?	Yes	No
Do you clench or grind your teeth?	Yes	No
Are you under a lot of stress?	Yes	No
Do you have frequent headaches?	Yes	No
Have you ever experienced any of the following problems in your jaw?		
Clicking	Yes	No
Pain (joint,ear or side of face)	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No

Do you like your smile?
If no, what would you change? ____

Are you nervous about receiving treatment?	Yes	No
Are you having any discomfort at this time?	Yes	No

If so describe: ____
Purpose of this appointment? ____

Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred during their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's accounts. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1-1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days from the date of the patient's examination.
In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected too, by me in writing, within the time for payment thereof. Additionally, I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you, or your assigns to telephone me at home or at my work to discuss matters related to this form. I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately knowing that providing inaccurate information can be dangerous to my health.

Signed: ____ Date: ______________

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer any treatment, or to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of possible complications of the procedures, anesthetics and/or drugs.

Signed: ____ Date: ______________
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: ___________________________________