CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, Photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)__________________________________'s dental needs.

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. 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 THE SERVICE unless other arrangements have been made. In the event payments are not received by agreed dates, I understand that a 1-1/2% late charge (18 APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's signature ____ Date

Parent/Responsible party's signature ____________________________________

Relationship to patient____

What is the reason for your visit today? ____

____

Date of last dental visit__________ Last dental cleaning ____________Last full mouth x-rays__________

What was done at your last dental visit? ____

Previous dentist name ______________________________ Telephone number__________________
How often do you have your dental examinations? ____
How often do you brush your teeth? ____
What other dental aids do you use? (interplak, toothpicks, etc.) ____________________________

Do you have any dental problems now? YES NO
If YES please describe ____

ARE YOUR TEETH SENSITIVE TO:
Hot or cold? YES NO
Sweets? YES NO
Biting or chewing? YES NO

Have you noticed any mouth odors
Or a bad taste? YES NO
Do you frequently get cold sores,
Blisters or any other oral lesion? YES NO

Do your gums bleed or hurt? YES NO
Have you experienced gum disease
Or tooth loss? YES NO
Have you noticed any loose teeth or
Change in your bite? YES NO
Does food tend to become caught
In between your teeth? YES NO
If YES where? ______________________________

DO YOU:
Clench or grind while awake or asleep? YES NO
Bite your lips or cheek regularly? YES NO
Hold foreign objects with your teeth?
(pencils, pens, fingernail, etc.) YES NO
Mouth breath while awake or asleep? YES NO
Have tired jaws, especially in the A.M.? YES NO
Smoke/chew tobacco? YES NO

HAVE YOU EVER HAD?
Orthodontic treatment? YES NO
Oral surgery? YES NO
Periodontal treatment?
(gum disease) YES NO
Your bite adjusted? YES NO
Serious injury to your
mouth or head? YES NO
IF SO PLEASE
DESCRIBE INCLUDING
CAUSE. ______________________________

____

HAVE YOU EXPERIENCED?
Clicking or popping in jaw? YES NO
Pain? (joint,ear, side of face) YES NO
Difficulty in opening or
closing mouth? YES NO
Difficulty in chewing ? YES NO
Headaches,neckaches,or
shoulder aches? YES NO
Sore muscles
(neck or shoulders) YES NO
Are you satisfied with the
appearance of your teeth? YES NO
Do you feel nervous? YES NO

Have you ever had an upsetting dental experience? ____
Is there anything else about dental treatment that you want us to know?

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