

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last Dental X-rays \_\_\_\_\_

Have you ever had an unpleasant Dental experience?      Y  N

(If yes, please describe, we want to make sure it does not happen again)

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Check (✓) if you have had problems with any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth               | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth/ broken fillings | <input type="checkbox"/> Sensitivity to sweets   |
| <input type="checkbox"/> Clicking/Popping jaw          | <input type="checkbox"/> Sores/ growths in mouth      | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth |   |  |

## AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and /or my dependent(s), have insurance coverage with \_\_\_\_\_  
*Name of Insurance Company (ies)*

and assign directly to Healthy Dental LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Healthy Dental LLC may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
*Signature of Patient, Guardian or Personal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please print name of Patient, Guardian or Personal Representative*

\_\_\_\_\_  
*Relationship to Patient*

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**