

4. Are you on a special diet? If yes, please describe: _____
 Have you lost or gained more than 10 pounds in the past year? Yes ___ No ___
5. Do you have sensitivity to metals or jewelry? Yes ___ No ___ Do you ever have a metallic taste in your mouth? Yes ___ No ___
6. Do you use more than two pillows to sleep? Yes ___ No ___ Do you ever wake up from sleep short of breath? Yes ___ No ___
7. Are you frequently thirsty? Yes ___ No ___ Do your ankles swell in the day? Yes ___ No ___
 Do you have to discontinue climbing stairs or walking due to shortness of breath, tiredness, or pain in your chest? Yes ___ No ___
8. Women: Are you pregnant or think you may be pregnant? Yes, ___ Months; No ___ Are you breastfeeding? Yes ___ No ___
 Do you use birth control medications? Yes ___ No ___

Dental History Information

Are you having dental pain or discomfort at this time? _____

When was your last dental exam and dental x-rays? _____ When was your last dental cleaning? _____

Have you ever had a bad dental experience in the dental office? If yes, please describe: _____

How would you describe your feelings about being a dental patient? ___ Relaxed ___ Slightly Nervous ___ Very Nervous ___ Terrified

How would you rate your present dental health? ___ Good ___ Fair ___ Poor

Please answer the following by circling "yes" or "no" to each item:

Are your teeth sensitive to sweets or hot/cold temperatures?	Yes	No
Are they painful when you chew or bite?	Yes	No
Do you get canker sores or cold sores?	Yes	No
Do your gums bleed or hurt?	Yes	No
Are you troubled with bad breath?	Yes	No
Have you ever been told you have gum disease?	Yes	No
Have you had periodontal surgery or root planing?	Yes	No
Have you ever had oral surgery or extractions?	Yes	No
Have you had prolonged bleeding following surgery?	Yes	No
Have you ever had a reaction to 'Novacaine' or any anesthetic?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you wake up with headaches, tired jaws or neck pain?	Yes	No
Do you have pain in your jaw joints, face or ears?	Yes	No
Do you have difficulty opening or closing your mouth?	Yes	No
Do you breathe through your mouth while awake or asleep?	Yes	No
Do you snore or have any sleeping disorders?	Yes	No
Do you use a night guard or oral appliance?	Yes	No
Do you smoke or use tobacco in any form?	Yes	No
Do you drink alcohol?	Yes	No
Do you drink soda or cola?	Yes	No
Are you happy with your teeth's appearance?	Yes	No
Would you like to discuss making your teeth whiter?	Yes	No
Would you like to discuss enhancing your smile?	Yes	No

Is there anything else about having dental treatment you would like us to know? _____

PATIENT AGREEMENT

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me for any dental treatment I have not paid for in full. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I understand that if I do not pay the entire balance within 60 days of the date of service, a late charge of 1.5% on the unpaid balance will be assessed each month. I realize that failure to keep this account current may result in my dentist being unable to provide additional dental services except for dental emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay all collection costs and reasonable attorney fees incurred in the attempt to collect any outstanding account balances.

I authorize the dentist to release any information, including the diagnosis and records of any treatment rendered to me during the period of my dental care, to third party payers an/or other health practitioners. I give permission to the staff members at Health Centered Dentistry to discuss my treatment, diagnosis, insurance, account information and scheduled appointments with the following family members/friends: _____

I understand a 24 hour notice is required for any scheduling changes, and that a cancellation fee will be applied to my account for broken appointments.

I have read and understand the proceeding. The information I have provided is accurate and complete. I grant permission for the dentist and his staff to provide necessary dental services to me on my behalf.

Signature of patient, parent or guardian: _____ Date _____