

**PATIENT INFORMATION**

- |  |   |   |
|--|---|---|
| 1. Are you having any dental problems now?                                     | Y | N |
| <i>If your answer is no, what is the reason for your visit today?</i> _____    |   |   |
| 2. Have you ever had an upsetting experience at the dentist?                   | Y | N |
| 3. Are you nervous concerning your dental treatment?                           | Y | N |
| 4. Have you ever experienced any pain in your jaw (TMJ)?                       | Y | N |
| 5. Do your gums bleed or hurt?   | Y | N |
| 6. Do you get food caught between any of your teeth?                           | Y | N |
| 7. Are any of your teeth loose?  | Y | N |
| 8. Are any of your teeth sensitive?  | Y | N |
| 9. Do you floss?   | Y | N |
| 10. Do you smoke?  | Y | N |
| 11. Do you chew tobacco?   | Y | N |
| 12. Do you grind your teeth?   | Y | N |
| 13. Would you be interested in orthodontics?                                   | Y | N |
| 14. If you could change anything about your smile or teeth, what would it be?  |   |   |
| 15. What are your expectations or biggest concern about your dental treatment? |   |   |

**I hereby authorize the Doctor to administer medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine. In case of default, I (we) promise to pay legal interest on indebtedness, 1 ½% a month finance charge on balance in excess of 60 days, together with such collections, costs, and reasonable attorney fees as may be required to effect collection of outstanding amounts.**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**