

PATIENT DENTAL HISTORY

1. Date of last visit to the dentist _____
2. Was all treatment completed? yes no
3. Have you ever had to have a tooth removed? yes no
If so, why and was a replacement advised? _____
4. Are any of your teeth painful or sensitive due to heat, cold or sweets? yes no
5. Do your gums bleed easily or do they feel irritated, tender or swollen? yes no
6. Have you ever been told you have gum disease (periodontal disease or pyorrhea)? yes no
7. Have you ever had gum (periodontal) treatment? yes no
8. Do you get canker sores or fever blisters in your mouth? yes no
If so, how often? _____
9. Have you ever had a local anesthetic (has your jaw ever been put to sleep)? yes no
10. Have you had any difficulties associated with previous dental treatment? yes no
11. Do you have frequent headaches? yes no
If so, how often? _____
12. Does your jaw ever pop? yes no
13. Do you ever have any discomfort or tiredness around your ears, eyes, throat, neck or shoulders? yes no
14. Does it hurt to open wide, take a big bite or chew? yes no
15. Have you ever had your teeth straightened? yes no
16. Are you satisfied with the appearance of your teeth? yes no
17. Do you feel that you can chew adequately? yes no
18. Are you nervous about dental treatment? yes no
19. Have you ever had instruction in the use of a toothbrush and dental floss? yes no
20. How often do you brush your teeth? _____ floss? _____
21. Do you use a hard or soft toothbrush?
22. Is there any dental condition that you feel the dentist should know about? yes no
23. Did you know extensive destruction of the bone under the gum can take place before you are aware of it? yes no
24. Do you clench your teeth during the day? yes no
Have you been made aware of clenching your teeth at night? yes no
25. Does food catch between your teeth? yes no
If so, where? _____

PAYMENT POLICY: In compliance with the Truth in Lending law here is our credit policy: **It is customary to take care of fees at the time service is rendered unless other arrangements have been made.** To assist you with this, we accept VISA, MasterCard, American Express & Discover.

The patient understands and agrees that he/she is responsible for all amounts due, and further agrees to pay any fees (including attorney's fees and other costs) associated with the collections as well as interest in the amount of 1.5% per month on amounts due more than 90 days.

If you have dental insurance, we will accept assignment on that portion of your charges which are covered by insurance. However, it must be understood that you will be responsible for immediate payment of any deductible amount not covered by insurance; in addition, you will be responsible for any portion of the assigned amount not paid by your insurance company within 60 days.

If Dental Insurance assignment is accepted, I authorize payment directly to Dr. Donna Thomas Moses of any group insurance benefits otherwise payable to me and agree to the release of information relating to this claim. I certify that the medical and dental history information is correct to the best of my knowledge and that I have read and accept the above credit policy terms. Please fill in the following:

Person Responsible _____

Dental Insurance Company _____ Policy No. _____

Insured Soc. Security No. _____ Date _____ Signature _____

Patient (Parent) Signature _____ Date _____

Reviewed By _____ Date _____