PATIENT INFORMATION

1. Are you having any dental problems now? Y N
   If your answer is no, what is the reason for your visit today? _____

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 snore at night? Y N

7. Have you been told you have sleep apnea? If yes, do you sleep with a C-PAP Machine? 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:**_ _ _ _ _ _ _ _

TURN OVER PLEASE