DENTAL HEALTH

Have you ever experienced any of the following problems with your jaw? Check all that apply:

☐ Clicking ☐ Pain
☐ Difficulty in opening and closing
☐ Difficulty Chewing

Do your gums bleed when brushing?

☐ Yes ☐ No

Do you clench or grind your teeth?

☐ Yes ☐ No

Have you ever had facial surgery?

☐ Yes ☐ No

Do you wear dentures or partials?

☐ Yes ☐ No

Are you having any pain or discomfort at this time?

☐ Yes ☐ No

Do you have frequent headaches?

☐ Yes ☐ No

Have you ever had any orthodontic treatments?

☐ Yes ☐ No

Have you ever had any type of trauma to your mouth, jaw, or face?

☐ Yes ☐ No

Are you pleased with the appearance of your teeth when you smile?

☐ Yes ☐ No

Are you nervous about dental treatment?

☐ Yes ☐ No

CONSENT TO TREATMENT

I have read the above policy and agree to abide by it.

I hereby give consent to My Community Dental Centers to provide dental treatment, including any procedures deemed necessary. I authorize the performance of examinations, x-rays, local anesthesia, anesthetics, sedatives, and other dental treatments rendered under the general, direct, or indirect supervision of the dentist and his/her associates and/or staff members, as deemed necessary. I understand that information regarding my appointment may be shared with my medical provider for coordination of care. This authorization will remain in effect until canceled in writing by me.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's First Name _____

Patient's Last Name _____

Patient's Date of Birth _____

Patient/Guarantor Signature

Date _____

Patient Representative _____

Authority/Relationship to Client _____