DENTAL HEALTH QUESTIONNAIRE

1. Are you having any discomfort at this time?.....Yes No
   If so, explain_____

2. Have you ever had any serious trouble with previous dental treatment?..Yes No
   If so, explain_____

3. Does dental treatment make you nervous?.....Yes No

4. Date of last dental visit. _____

5. How often do you brush? _____

6. Your brush is ... Soft Medium Hard.

7. How often do you floss?_____

8. Do you use tobacco in any form?_____

9. Do you have or have you had any of the following?

Mouth:			**Teeth:**		
Bleeding, sore gums	yes	no	Loose teeth	yes	no
Unpleasant taste/ bad breath	yes	no	Sensitive to hot	yes	no
Burning tongue/lips	yes	no	Sensitive to cold	yes	no
Frequent blisters, lips/mouth	yes	no	Sensitive to sweets	yes	no
Swelling/lumps in mouth	yes	no	Sensitive to biting	yes	no
Orthodontic treatment (braces)	yes	no	Food impaction	yes	no
Biting cheeks/lips	yes	no	Shifting in bite	yes	no
Difficulty opening or closing jaw	yes	no	Clenching/grinding	yes	no
Other_____			if so when?_____		
			Other_____		

PRIMARY DENTAL INSURANCE

Responsible Party: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone:_____ Relation to Patient: _____

SS NO: _____ Date of Birth: _____ Sex: M / F

Employer:_____
(Name) (Address and Phone Number)

Insurance Co: _____ Group Number: _____

Address: _____
(Street) (City) (State) (Zip Code)

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for serviced rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
Signature of Parent or Guardian **Date**

Payment is due in full at the time of treatment unless prior arrangements have been approved.