

DO YOU:

	Yes	No
Do you get food caught between any particular teeth?	<input type="radio"/>	<input type="radio"/>
Have an unpleasant odor in your mouth?	<input type="radio"/>	<input type="radio"/>
Chew on only one side of your mouth?	<input type="radio"/>	<input type="radio"/>
Have any growth or swelling in your mouth or neck?	<input type="radio"/>	<input type="radio"/>
Feel pain or discomfort when:		
Your teeth come together?	<input type="radio"/>	<input type="radio"/>
You eat hot foods (coffee, soup)?	<input type="radio"/>	<input type="radio"/>
You eat cold foods (ice water)?	<input type="radio"/>	<input type="radio"/>
You eat sweets?	<input type="radio"/>	<input type="radio"/>

HAVE YOU EVER NOTICED:

Pain or soreness in either jaw joint?	<input type="radio"/>	<input type="radio"/>
Popping, clicking or grating in either jaw joint?	<input type="radio"/>	<input type="radio"/>
Chronic or tension headaches?	<input type="radio"/>	<input type="radio"/>
Difficulty in opening your mouth widely?	<input type="radio"/>	<input type="radio"/>
Difficulty in closing your mouth?	<input type="radio"/>	<input type="radio"/>
That you clench or grind your teeth during daytime hours?	<input type="radio"/>	<input type="radio"/>
That you clench or grind your teeth at night?	<input type="radio"/>	<input type="radio"/>

Have you lost any teeth? _____ From what cause? _____ Have they been replaced? _____

Do you have removable bridgework? _____ For how long? _____

Do you feel that eventually you will wear full artificial dentures? _____

Do you want to retain your teeth for life? _____

Have you ever been told you have Pyorrhea or Gum Disease? _____ When? _____

Have you ever had instruction on the correct method of brushing your teeth? _____

How often do you brush your teeth? _____

Have you ever had instruction on the care of your gums? _____

Do you use dental floss? _____ How often? _____

Do your gums bleed when you brush? _____ Floss? _____

Do you have any dental or medical disease, condition, or problem not listed above that you think the doctor should know about? _____ If yes, please explain. _____

Do you use tobacco? _____ What kind? _____ Amount each day? _____

CONSENT

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs

I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I understand 24 hours notice is required for any changes in scheduling or a failure fee of 50% of the total scheduled fee will be incurred.

Patient or Responsible Party _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I have received a copy of this office's Notice of Privacy Practices. I understand the office has the right to change the privacy practices as described and will issue a revised Notice of Privacy Practices, which will contain the changes.

Patient or Parent /Guardian _____ Date _____

Office Use Only

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)