Atlas Cosmetic & Family Dentistry OF PLANO

BASIC INFORMATION
MUST COMPLETE ALL SECTIONS!!

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

PATIENT OR PARENT'S EMPLOYER _____

HOW DID YOU HEAR ABOUT US? _____

BASED ON YOUR WORK & OTHER SCHEDULES, WHEN IS THE BEST TIME TO CONTACT YOU? _____

WHAT IS YOUR PREFERRED CONTACT METHODE? ☐ CALL ☐ TEXT

ARE YOU FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? YES NO
IF NO PLEASE FILL OUT BELOW ABOUT THE RESPONSIBLE PARTY ⬇

YOUR DATE OF BIRTH
_____

YOUR CELL PHONE NUMBER
_____

YOUR HOME / SECONDARY PHONE NUMBER
_____

YOUR SOCIAL SECURITY NUMBER
_____

CIRCLE WHICH ONE APPLIES TO YOU?

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

YOUR EMERGENCY CONTACT INFO

Name: _____

Phone #: _____

FINANCIALLY RESPONSIBLE PARTY

ARE YOU THE FINANCIAL RESPONSIBLE PARTY FOR TREATMENT? YES NO
IF YES, DO NOT FILL THE REST OF THIS SECTION.

NAME OF THE PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT
_____

RELATIONSHIP TO PATIENT _____

DATE OF BIRTH OF THIS PERSON: _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

THIS PERSON'S SOCIAL SECURITY NUMBER: _____

DO YOU HAVE DENTAL INSURANCE? ☐ YES / ☐ NO

NAME OF THE INSURANCE COMPANY
_____

IS THIS A PPO DENTAL INSURANCE?
☐ YES / ☐ NO

FINANCIALLY RESPONSIBLE PERSON'S MAIN CELL PHONE NUMBER
_____

THEIR SECONDARY PHONE NUMBER
_____

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are **ultimately your responsibility**.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. All insurance benefits are assigned to the Doctor unless services are paid in full on the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require 48 hours notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitment. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 25% down** to hold the appointed time.

CONSENT

I have read and understood all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature_____ (Patient, Parent or Guardian) Date _____

[English]

Dear Patients,

For any dental treatments over $500 we require a 25% **NON-REFUNDABLE** down payment to book your appointment. This is to ensure your commitment to proceed with treatment with our office. Late cancellations or changes in scheduled appointments hurt our office. We appreciate you choosing our office for your dental and oral healthcare needs. Please note that changes in plans or late cancellations result in forfeiture of your deposit.

[Farsi (Direct translation of above)]

مراجعین عزیز

برای هر گونه درمان دندانپزشکی بیش از 500 دلار، نیاز به 25٪ پیش پرداخت غیر قابل استرداد برای رزرو نوبت شما داریم .این پیش پرداخت برای اطمینان از تعهد شما به ادامه درمان با مطب ما است .لغو دیرهنگام یا تغییر در قرارهای برنامه ریزی شده به دفتر ما آسیب می رساند .از اینکه مطب ما را برای نیازهای بهداشتی دندان و دهان خود انتخاب کرده اید سپاسگزاریم .لطفاً توجه داشته باشید که تغییر در برنامه ها یا لغو دیرهنگام نوبت شما منجر به ضبط سپرده شما می شود

Signature_____ (Patient, Parent or Guardian)

Date _____

Health Insurance Portability and Accountability Act Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (469) 367 0266.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment, we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Atlas Cosmetic & Family Dentistry of Plano does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. Safeguarding Your Personal & Health Information.

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Atlas Cosmetic & Family Dentistry of Plano maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Atlas Cosmetic & Family Dentistry of Plano.

The State of Texas requires that anyone who is prescribed a controlled substance (narcotic) will have their information entered into a nationwide database. The Drug Prescription Monitoring database is very secure, as only physicians and law enforcement can access the database. If you do not wish to have your information entered into this database, please inform the doctor and he will prescribe you a non-narcotic.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Atlas Cosmetic & Family Dentistry of Plano occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

Signature: _____ Date: _____

Electronic Communication Consent Form

After reading your rights under HIPAA Notice, this form is to gather your consent and permission to communicate with you electronically and also obtain your permission and consent to send any notices and disclosures to you electronically via email or text.

Electronic Text Communication

We utilize a 2-way texting service to communicate with our patients which may include but not limited to patient appointments, reminders, billing, notices, disclosures, dental & medical records, insurance matters, personal information, and many other types of information. The communications will be sent to the cell phone number you provided to us which is on file. The intended recipient is always you the patient; however, we have no control over the information that is contained within your personal cell phone and its dissemination. Other third parties and applications within your cellular device may access the communicated information. Please note that the accuracy of the phone number you provide to us or any subsequent changes to your cell phone number is entirely your responsibility. You must inform us right away if your phone number is changed or is no longer being used by you. Delays in doing so may expose your data to unauthorized third parties.

Electronic Email Communication

We utilize Google email (Gmail) services to communicate with our patients which may include but not limited to patient appointments, reminders, billing, notices, disclosures, dental & medical records, insurance matters, personal information, and many other types of information. The communications will be sent to the email you provided to us which is on file. The intended recipient is always you the patient; however, we have no control over the information that is contained within your email inbox, email account, or associated devices with your email and its dissemination. Other third parties and applications within your email inbox, email account, or associated devices with your email, may access the communicated information. Please note that the accuracy of the email you provide to us or any subsequent changes to your email is entirely your responsibility. You must inform us right away if your email is changed or is no longer being used by you. Delays in doing so may expose your data to unauthorized third parties.

CONSENT

I have read and understood all the above information. I hereby acknowledge that I am informed about all the risks associated with the use of electronic communications and understand my responsibilities in protecting my private and health information. By signing below, I am consenting to the 2-way texting and email communication that is utilized at Atlas Cosmetic & Family Dentistry of Plano. Furthermore, I hereby agree to indemnify and hold Atlas Cosmetic & Family Dentistry of Plano and all its agents and employees harmless from any unauthorized access to my protected health or personal information. Finally, my signature below authorizes Atlas Cosmetic & Family Dentistry of Plano to communicate with me via text or email and I agree that all such communications are as binding and effective as regular mail or in person communications.

Signature _____ Date _____

(Patient, Parent or Guardian)

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatment options or the option of no treatment.

It is very important that you provide Atlas Cosmetic and Family Dentistry of Plano with an accurate medical history before, during and after treatment. It is equally important that you follow your Dentist's advice and recommendations regarding medications, before and after treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your Dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. **Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.**

During your course of treatment, the following care may be provided to you:

• **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnose any x-rays taken. In the state of Texas, a dental hygienist ***cannot*** diagnose a patient.

• **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus ***above the gum line*** and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

• **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled, the dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dentist will stop the routine cleaning and explain to you the alternative treatment plans including nonsurgical cleaning ***below the gum line (Deep Cleaning)***, placement of an antibiotic or antimicrobial below the gum line or a gross debridement (two-part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our dentist. **The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow any other recommendations.** Some bleeding after deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature, the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. I understand and accept the financial responsibility for such adjustments made to the treatment plan.

Allergies/Medication

I have informed Atlas Cosmetic and Family Dentistry of Plano of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs.

I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Consent

I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

Patient Full Name: _____

Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment and Deductible, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____ _____

Signature of Patient/Responsible Party Date

909 W Spring Creek Pkwy, Suite 490, Plano, TX, 75023

Office Phone Number: (469) 367 0266 Office Fax Number: (469) 649 1291

Insurance In/Out of Network Notice

Dear patient,

This notice is to inform you that our office may be out of Network with your insurance carrier. What this means is that we may not be contracted with your insurance company to accept their terms, conditions, contracted fees, limitations on treatment, age limitations, limitations on frequency of treatment, limitations on type of restoration and/or treatment payable by your insurance carrier. We do not adjust our standard of care, services, or the type of treatment necessary for optimal care for our patients based on the patient's type of insurance and insurance terms and conditions. Please note you may have a higher bill by seeing an out of Network provider. Insurance companies constantly change their rosters and policies, and it is extremely difficult and time consuming for us to confirm if you are in network or not. We assume in network or out of network status based on historical data and our previous insurance claim histories. However, please note that it is solely your responsibility to ensure that our office and/or our doctor/s are in network or out of network with your insurance carrier.

As a courtesy to you, we are going to bill your insurance on your behalf at no extra cost to you. We may collect a lower fee from you than our standard fees in anticipation of your insurance's benefits available and payable to us. Alternatively, we may choose to charge you our standard fees up front and then bill your insurance so they may send you a check as reimbursement. **Please note that all of our estimations of what your insurance is going to pay is just that: an estimation and it is not a guaranteed that your insurance is going to pay the exact amount of our estimation. Should there be a balance left after an insurance payment, you are acknowledging by signing below that you are financially responsible for any such balance difference.** Please note that due to many factors such as insurance maximums, deductibles, frequency limitations, age limitations and many other terms and conditions of your insurance carrier, the total pay from your insurance may be less than our estimation. Please note that it is your responsibility to know your insurance carrier, their policy, their coverages, and limitations, we are only billing the insurance on your behalf at no extra cost to you, we are informing you here that we are not responsible for what your insurance may or may not pay. By signing below, you are acknowledging your financial responsibility in paying any balance that remains after an insurance payment. Thank you for choosing us to be your dental home. We look forward to serving you and your family.

Patient Signature: _____

Date: _____ / _____ / _____

PATIENT MEDICAL HISTORY

Please Fill out this form entirely

YOUR FULL NAME _____

PARENT/LEGAL GUARDIAN FULL NAME _____

ARE YOU UNDER THE CARE OF A PHYSICIAN ☐ YES ☐ NO

MEDICAL DOCTOR NAME _____

DATE OF LAST MEDICAL EXAM _____

HAVE YOU BEEN HOSPITALIZED OR HAD SURGERIES IN THE LAST SIX YEARS? ☐ YES ☐ NO

DO YOU USE TOBACCO? ☐ YES ☐ NO

DO YOU USE ALCOHOL? ☐ YES ☐ NO

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU WEAR CONTACTS? ☐ YES ☐ NO

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? ☐ YES ☐ NO

HAVE YOU EVER HAD A RADIATION THERAPY DONE TO YOUR HEAD OR NECK FOR CANCER TREATMENT? ☐ YES ☐ NO

HAVE YOU EVER HAD A REACTION TO ANESTHETIC? ☐ YES ☐ NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

ASPIRIN	☐ YES	☐ NO
PENICILLIN	☐ YES	☐ NO
CODEINE	☐ YES	☐ NO
ACRYLIC	☐ YES	☐ NO
METAL	☐ YES	☐ NO
LATEX	☐ YES	☐ NO
SULFA DRUGS	☐ YES	☐ NO

ANY OTHER ALLERGIES: _____

Atlas Cosmetic & Family Dentistry OF PLANO

MEDICAL DOCTOR PHONE NUMBER _____

WOMEN ONLY:

ARE YOU PREGNANT? ☐ YES ☐ NO

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

Patients with Dental Anxiety & Phobias:

*Will you be needing Nitrous sedation (Laughing gas)

☐ YES ☐ NO
☐ interested but want to learn more

*Will you be needing Conscious sedation

☐ YES ☐ NO
☐ interested but want to learn more

Please Answer the following:

WHAT IS YOUR WEIGHT?
_____ lbs OR _____ Kg

WHAT IS YOUR HEIGHT?

_____ ' _____ "

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:

HIGH BLOOD PRESSURE	Yes ☐	No ☐	FREQUENTLY TIRED	Yes ☐	No ☐
LOW BLOOD PRESSURE	Yes ☐	No ☐	ANEMIA	Yes ☐	No ☐
HEART DISEASE	Yes ☐	No ☐	STROKE	Yes ☐	No ☐
HEART ATTACK	Yes ☐	No ☐	CHEST PAIN/ANGIA	Yes ☐	No ☐
CARDIAC PACEMAKER	Yes ☐	No ☐	HEART MURMER	Yes ☐	No ☐
ASTHMA	Yes ☐	No ☐	CANCER HISTORY	Yes ☐	No ☐
DIABETES	Yes ☐	No ☐	LEUKEMIA	Yes ☐	No ☐
RHEUMATIC FEVER	Yes ☐	No ☐	EMPHYSEMA	Yes ☐	No ☐
SWOLLEN ANKLES	Yes ☐	No ☐	ARTHRITIS	Yes ☐	No ☐
FAINTING/SEIZURES	Yes ☐	No ☐	GLAUCOMA	Yes ☐	No ☐
JOINT REPLACEMENT	Yes ☐	No ☐	LIVER DISEASE	Yes ☐	No ☐
EPILEPSY/CONVULSIONS	Yes ☐	No ☐	ULCERS	Yes ☐	No ☐
SHORT OF BREATH	Yes ☐	No ☐	KIDNEY DISEASE	Yes ☐	No ☐
HAY FEVER/ALLERGIES	Yes ☐	No ☐	HEPATITIS A, B OR C	Yes ☐	No ☐
TUBERCULOSIS	Yes ☐	No ☐	AIDS/HIV INFECTION	Yes ☐	No ☐
RESPIRATORY PROBLEM	Yes ☐	No ☐	STD'S	Yes ☐	No ☐
THYROID PROBLEMS	Yes ☐	No ☐	HIGH CHOLESTEROL	Yes ☐	No ☐

ANY OTHER MEDICAL CONDITIONS:

____

____

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____

ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION.

☐ YES ☐ NO

PLEASE WRITE ALL MEDICATIONS:

____

____

____

____

____

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____

____

____

____

____

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	1. ☐ YES ☐ NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	2. ☐ YES ☐ NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	3. ☐ YES ☐ NO
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	4. ☐ YES ☐ NO
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?	5. ☐ YES ☐ NO
6. HAVE YOU EVER HAD TRAUMA TO YOUR FACE MOUTH OR JAW?	6. ☐ YES ☐ NO
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?	7. ☐ YES ☐ NO
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?	8. ☐ YES ☐ NO
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?	9. ☐ YES ☐ NO
10. DO YOU HAVE DIFFICULTY CHEWING?	10. ☐ YES ☐ NO
11. DO YOU HAVE FREQUENT HEADACHES?	11. ☐ YES ☐ NO
12. DO YOU CLENCH OR GRIND YOUR TEETH?	12. ☐ YES ☐ NO
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	13. ☐ YES ☐ NO
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?	14. ☐ YES ☐ NO
15. HAVE YOU EVER HAD BRACES?	15. ☐ YES ☐ NO
16. DO YOU USE ANY TYPE OF MOUTH RINSE?	16. ☐ YES ☐ NO
17. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?	17. 1X/DAY ☐ 2X/DAY ☐ 3X/DAY ☐
18. HOW OFTEN DO YOU FLOSS?	18. 1X/DAY ☐ 2X/DAY ☐ 3X/DAY ☐
19. DO YOU USE A MANUAL BRUSH OR ELECTRIC?	19. MANUAL ☐ ELECTRIC ☐

WHAT ARE YOUR GOALS FOR YOUR MOUTH/TEETH?

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____

PATIENT SIGNATURE **DATE**

_____

DENTIST SIGNATURE

_____

DATE

_____

WITNESS SIGNATURE

_____

DATE