Emergency Contact

Name of Relative or Person NOT LIVING with you________________________ **Relationship to you**________________________

Phone________________ **Address**____

Dental History

Name of Previous Dentist;________________________ **Last Dental Visit?**________ **Reason for today's visit?**________________________

Have you ever had a serious problem associated with a previous dental treatment? **Yes [ ] No [ ]**

If "Yes" explain____

How often do you brush?____________ **How often do you floss?**________________ **How often do you get cleanings?**________________

What dental aids do you use? Floss [ ] **Toothpick [ ] Water Pick [ ] Electric / Sonicare Toothbrush [ ] Other ________________ [ ]**

Please answer Yes [ ] *or* No [ ].

Are you hesitant to come to the Dentist? Yes [ ] No [ ]

Do your gums bleed during brushing or flossing? Yes [ ] No [ ]

Do you have a bad taste or odor in your mouth? Yes [ ] No [ ]

Does food frequently get caught between your teeth? Yes [ ] No [ ]

Do you have dental fillings that you don't like? Yes [ ] No [ ]

Do you believe in the benefits of fluoride? Yes [ ] No [ ]

Do you snore or have trouble sleeping? Yes [ ] No [ ]

Would you like to have a whiter and brighter smile? Yes [ ] No [ ]

Would you like to have straighter teeth? Yes [ ] No [ ]

Do you have missing teeth that you want replaced? Yes [ ] No [ ]

Do you have loose dentures or partials? Yes [ ] No [ ]

Are you wearing away your teeth? Yes [ ] No [ ]

What do you NOT like about your smile?____

What can we do to make your smile look better?____

Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize Your Expressions to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment: In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection sums due and unpaid for the work herein set forth.

Signature:________________________________ **Date:**________________

Children or Minors

Because (name of child)________________________ **is a minor, it is necessary that signed permission be obtained from a parent or** guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment

Signature:________________________________ **Date:**________________