DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last Dental X-rays _____

Have you ever had an unpleasant Dental experience**?** **Y** ☐ N ☐

(If yes, please describe, we want to make sure it does not happen again)

_____

_____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking/Popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth/ broken fillings
- ☐ Sores/ growths in mouth
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and /or my dependent(s), have insurance coverage with _____

Name of Insurance Company (ies)

and assign directly to Dental Glitters all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dental Glitters may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative *Date*

_____ _____

Please print name of Patient, Guardian or Personal Representative *Relationship to Patient*

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