Bush Family Dentistry

Dental History

Name:_____

Reason for your visit today

_____

Former Dentist _____ City/State _____

Date of last Dental exam _____Date of last dental x-ray _____

How often do you floss? _____ How often do you brush? _____ What type of toothbrush do you use? Soft ☐ Medium ☐ Hard ☐

Has fear or discomfort kept you from dental visits or cares? Yes ☐ No ☐ If yes, please Explain_____

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐ If no, please Explain_____

Have you had any unusual reaction to dental anesthesia (gas or injections)? Yes ☐ No ☐ If yes, please explain_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following :

Bad Breath	Yes ☐	No ☐
Bleeding gums	Yes ☐	No ☐
Pain around ear	Yes ☐	No ☐
Blisters on lips or mouth	Yes ☐	No ☐
Burning sensation on tongue	Yes ☐	No ☐
Chew on one side of mouth	Yes ☐	No ☐
Clicking or popping jaw	Yes ☐	No ☐
Dry mouth	Yes ☐	No ☐
Fingernail biting	Yes ☐	No ☐
Food collection between the teeth	Yes ☐	No ☐
Grinding teeth	Yes ☐	No ☐
Gums swollen or tender	Yes ☐	No ☐
Jaw pain or tiredness	Yes ☐	No ☐
Lip or cheek biting	Yes ☐	No ☐
Loose teeth or broken teeth	Yes ☐	No ☐
Mouth breathing	Yes ☐	No ☐
Mouth pain, brushing	Yes ☐	No ☐
Orthodontic treatment	Yes ☐	No ☐
Periodontal treatment	Yes ☐	No ☐
Dental Implant	Yes ☐	No ☐
Sensitivity to cold	Yes ☐	No ☐
Sensitivity to hot	Yes ☐	No ☐
Sensitivity to sweets	Yes ☐	No ☐
Sensitivity when biting	Yes ☐	No ☐
Sores or growths in your mouth	Yes ☐	No ☐

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my or (dependents) health care, advice and treatment provided for the purpose of evaluating and Administering claims for insurance benefits.

I authorize release of any information concerning my (or dependents) health care and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental insurance is a *contract between the insurance carrier and me* and not between the insurance carrier and the dentist, and that I am ultimately responsible for all dental fees. If payment from my insurance carrier is not received within 30 days, I understand that I will be responsible for payment of my treatment fees and collection of benefits directly from my insurance carrier.

I understand that I will be charged for all dental treatment and any payments received by the dental office from my insurance coverage will be credited to my account, or refunded to me if I have previously paid the dental fees incurred.

I understand that I am expected to pay the total amount of fees on the day of service. If I do not pay the entire amount, a finance charge will be added to the account for the current monthly billing period, which is an annual percentage rate of 18% applied to the last month's balance.

In case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

I understand that upon my request I will be provided with a copy of the HIPAA privacy policy.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date_____