DENTAL

Are you in dental discomfort today?_____

Former Dentist: _____Phone: _____

Date of last dental visit: _____Date of last x-rays: _____

Please circle if you have had problems with any of the following:

Bad Breath	Food Collection Between Teeth	Periodontal Treatment
Bleeding Gums	Grinding or Clenching Teeth	Sensitivity to Hot or Cold
Clicking or Popping Jaw	Loose or Brooken Teeth	Sores or growths

How often do you brush?_____ Floss? _____

How do you feel about the appearance of your teeth? _____

MEDICAL

Physician Name:_____ Phone:_____

Date of last Visit:_____ Have you had any serious Illness **or** Operation? ❒ **YES** ❒**NO**

If **yes**, please explain: _____

Women: Are you Pregnant? ❒ **YES** ❒ **NO** Nursing? ❒ **YES** ❒ **NO** Taking birth Control pills? ❒ **YES** ❒ **NO**

CIRCLE any of the following conditions you have or have had in the past:

AIDS/HIV Positive Heart	Cortisone Treatment	Hepititis	Skin Rash
Anaphylaxis	Cough, Persistent	High Blood Pressure	Spinal Bifida
Anemia	Cough up Blood	Jaw Pain	Stroke
Arthritis, Rheumatism	Diabetes	Kidney Disease	Surgical Implant
Artificial heart Valve	Epilepsy	Liver Disease	Thyroid Disease
Artificial Joints	Fainting	Material Allergy (Latex/Metal)	Tobacco Habit
Asthma	Food Allergy	Mitral Valve Prolapse	Tonsillitis
Atopic (allergy prone)	Glaucoma	Nervous Problems	Tuberculosis
Back Problems	Headaches	Pacemaker/Heart Surgery	Ulcer/ Colitis
Blood Disease	Heart Murmur	Psychiatric care	Venereal Disease
Cancer	Heart Problems	Radiation Treatment	
Chemical Dependency	Hemophilia/Abnormal Bleeding	Respritory Disease	
Circulatory Problems	Herpes	Rheumatic/ Scarlet	

List any medications you are currently taking:_____

List any drug allergies if any:_____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Power Ranch Dental and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Power Ranch Dental and/or their trained staff to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists. Payment in full for all charges is required at the time of visit, unless prior arrangements have been made.You, the patient/ responsible party, are ultimately responsible for payment in full on your account, not the insurance company. We do however; file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient/ responsible party. All delinquent accounts (30 days or older) are subject to reasonable service charges and/ legal interest rates. In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

_____ _____

Signature of Patient / Parent or Guardian **Date**