DENTAL HISTORY

Reason for todays visit:_____
Former Dentist:_____
City/State:_____
Date of last dental visit:_____
Date of last dental X-rays:_____

Please circle "yes" or "no" to indicate if you have had any of the following:

Y / N Bad breath
Y / N Bleeding gums
Y / N Blisters on lips or mouth
Y / N Burning sensation
Y / N Chew on one side of mouth
Y / N Cigarette, pipe or cigar smoking
Y / N Clicking or popping jaw
Y / N Dry Mouth
Y / N Fingernail biting
Y / N Food collection between the teeth
Y / N Foreign objects
Y / N Grinding teeth
Y / N Gums swollen or tender
Y / N Jaw pain or tiredness
Y / N Lip or cheek biting
Y / N Loose teeth or broken fillings
Y / N Mouth breathing
Y / N Mouth pain, brushing
Y / N Orthodontic treatment
Y / N Pain around ear
Y / N Periodontal treatment
Y / N Sensitivity to cold
Y / N Sensitivity to heat
Y / N Sensitivity to sweets
Y / N Sensitivity when biting
Y / N Sores or growth in your mouth

How often do you floss?_____
How often do you brush?_____

Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. Mark T. McGuire, DDS 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.

The above-named dentist 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. The consent will end when my current treatment plan is complete or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient