Michael S. Singleton, D.D.S., PLLC
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Last Name _____ First Name _____ DOB _____ Date _____

DENTAL HISTORY QUESTIONS:	YES	NO
How often do you brush your teeth?		
How often do you floss?		
Do your gums bleed or hurt when brushing?		
Does food catch between your teeth?		
Do you have difficulty chewing?		
Do you avoid any part of the mouth while brushing?		
Have you ever had any teeth removed?		
How long have these teeth been missing?		
Do you feel you will eventually wear artificial dentures?		
Have you ever had a reaction to local anesthetic?		
Are your teeth sensitive to:		
• Heat?		
• Cold?		
• Sweets?		
• Biting Pressure?		
Have you noticed gum swelling around any teeth?		
Do you have any unpleasant tastes or odors in your mouth?		
Problems of the jaw:		
• Clicking of the jaw?		
• Pain (joints, ear, neck, head)?		
• Difficulty opening or closing?		
• Do you clench or grind your teeth while awake or asleep?		
Are you dissatisfied with your teeth and their appearance? If so, please describe:		
Are you deeply concerned about the finances required to restore you teeth to excellent dental health?		
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?		
Do you have any fears?		
When was your last dental appointment?		
When was your last dental cleaning?		
Have you ever been told you have Periodontal Disease or undergone treatment for it?		
Have you ever been told to take a premedication prior to dental treatment?		
Why did you leave your last dentist?		
What is your present dental problem?		
Is there anything else about having dental treatment that you would like us to know?		

CONSENT FOR TREATMENT

I hereby authorize Dr. Singleton and his staff to take x-rays, study models, photographs, and other diagnostic aids that are deemed appropriate for diagnostic purposes. Upon such diagnosis, I authorize Dr. Singleton and his staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

FINANCIAL AGREEMENT

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If you have dental insurance, our office can submit charges to your insurance carrier. Co-payments and deductibles, or payment in full, is due at the time service is rendered. We accept cash, check, MasterCard, Visa, Discover, American Express and CareCredit. I understand that I am responsible for payment of all services, regardless of any insurance company's arbitrary determination of payment, and I agree to this policy.

ACKNOWLEDGEMNT OF RECEIPT OF PRACTICE'S NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other related federal laws, I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I have been given the opportunity to review and ask any questions I may have regarding this Notice.

Patient/Guardian Signature _____ Date _____