

Physician's Name \_\_\_\_\_ Physician's # \_\_\_\_\_  
Physician's Address \_\_\_\_\_ Last Medical Exam \_\_\_\_\_  
In case of emergency, contact \_\_\_\_\_ Telephone \_\_\_\_\_

**Dental History:**

Reason for visit:

Last Dental Visit

Last complete x-rays (18 films or Panorex)

Have you ever been diagnosed or treated for Periodontal (GUM) Disease YES\_\_ NO\_\_

Do your gums ever bleed? YES\_\_ NO\_\_

Do you have an unpleasant taste in your mouth? YES\_\_ NO\_\_

Do you grind or clench your teeth? YES\_\_ NO\_\_

Have you ever had any dental treatment recommended that was not done? YES\_\_ NO\_\_

If yes, explain YES\_\_ NO\_\_

Would you like to change the appearance of your smile? YES\_\_ NO\_\_

If yes, explain YES\_\_ NO\_\_

Have you ever had any serious problems with past dental treatment? YES\_\_ NO\_\_

If yes, explain

Which of our patient's referred you?

How did you hear about our office?

So that we can best serve you, may we ask why you left your last dental office?

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance with \_\_\_\_\_

Name of Insurance Company (is) and assign directly to **King and Roberts PLC**. All benefits, if any, otherwise payable to me for services rendered I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Date Signature

**MINOR/ CHILD CONSENT**

I, being the parent or guardian of

\_\_\_\_\_  
Name of minor/child

Do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

\_\_\_\_\_  
Date Signature of Insured/Guardian

**FINANCIAL AGREEMENT**

I acknowledge that payment is *due* at time of treatment, unless other arrangements are *made*. I agree that Parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature