DENTAL HISTORY (Self-Assessment)

Referring Dentist Name______________________________City______________

Briefly describe your problem____

How long have you had this problem? ____Day(s) ____Week(s) ____Month (s) ____Years (s)

Please check all that apply:

Location:

Upper: ☐ Right ☐Left ☐ Front

Lower: ☐ Right ☐Left ☐ Front

Pain:

☐ Never ☐ Today (please rate 0-10_____) ☐ In the Past (please rate 0-10_____)

Duration: ☐ Seconds ☐ Minutes ☐Hours ☐ Constant

Quality: ☐ Dull pain ☐Throbbing pain ☐ Sharp pain

Provoked By: ☐ Cold ☐ Hot ☐ Biting ☐ Sweets ☐ Spontaneous (unprovoked) ☐ Other________

Swelling: ☐ None ☐Today ☐ Past

Please rate today's anxiety level (0-10)__________

Would you like to use Nitrous Oxide (Laughing Gas) during your treatment? ☐ Yes ☐ No

**There is an additional fee of $60 for Nitrous Oxide, which insurance does not cover.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

Print Patient Name______________________________Date______________

Signature______________________________Relationship to patient______________

I give permission for the listed person(s) below to have access to my protected health information:

Names____

Office Use Only:

I have attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented:

Date______________ Initials________ Reason______________________________

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