Patient Dental History

Name ____

Name of Previous Dentist ____

Date of Last Dental X-rays ____

How long since your last dental visit? ____

Reason for today's visit: □ Check-up □ Pain □ Other ___________________________________

Have you ever been treated for Periodontal Disease? _____________________________________

Have you had any complications or bad experiences at the dentist? _________________________

____

____

Please share any questions or concerns that you would like us to know about: _______________

____

____

Patient Name: ____

Birth Date:____________________

I HEREBY AUTHORIZE HORIZONS DENTAL TO SHARE:

Any and all information that relates to my dental health.

WITH THE FOLLOWING PEOPLE:

Full Name: ______________________________________ Relationship: __________________
Full Name: ______________________________________ Relationship: __________________
Full Name: ______________________________________ Relationship: __________________
Full Name: ______________________________________ Relationship: __________________

I understand that I may cancel this consent at any time (by writing to Horizons Dental), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider to share my information with someone. This authorization does not expire unless I cancel it in writing or request it be updated by signing a new form.

Signature: ____ Date: ___________________