		DENTA	IL HISTORY		
What is yo	our immediate pro	blem?			
Have you ever had periodontal treatment?				When:	
What is yo	our maintenance c	leaning schedule?		When was your last cleaning?	
		CC	INSENT		
				every patient has the Right of Privacy concer opy of the Notice of Privacy Practices and und	
X Signed:				Date	
	ree to pay together			narges not covered by this authorization. In the onsible attorney's fees as may be required.  **Date**	
The unders deemed ap	signed hereby authoropropriate by the Do	ctor to make a thorouseatment, medication a	igh diagnosis and therapy, t	s, study models, photographs, or any other dof the patient's dental needs. I also authorize that may be indicated in connection with (Name consent that Doctor choose and employ such	e the Doctor to ne of Patient)
for Dental Strendered. In	Services provided in the event of defau	e use of anesthetic ag this office for myself	gents embodie or my dependay legal intere	es a certain risk. I understand that responsibe tents is mine, due and payable at the time se st on the indebtedness, together with such co	ility for payment rvices are
X Patient:			Date	Witness	
X Parent or Responsible Party			Relationship to Patient		
			PDATES		
Date	No Changes	Changes:		Patient Signature:	
Date	No Changes	Changes:		Patient Signature:	
Date	No Changes	Changes:		Patient Signature:	