

## truForm Usage Instructions

**To use this form you must have Acrobat Reader 5 or greater installed.**

[Click here](#) to download the current version of Adobe Acrobat Reader.

- Use the tab key to move from form field to form field.
- To enter in text, tab to (or click in) the area you wish to type in and begin typing.
- To check off choices on the form (yes/no type), click in the boxed or underlined area and an “x” or check mark should appear.
- To print out a copy of the form to retain for your records, click on the “Print Form” button toward the bottom of the last page.
- To send the completed form to our office, click “Submit Form” button toward the bottom of the last page.

**If you experience difficulty submitting this form, please follow these directions:**

1. **Print the form.**
2. **Complete with black pen and bring the form to the office at the time of your appointment.**
3. **If you do not have a printer, you can fill out the form at the office prior to your appointment.**

Please fill out the form as completely as possible. If you have any questions, please contact your doctor.

### **For your protection:**

This form is hosted on a secure server and can only be viewed by our office. Please feel confident in filling out this form, as all of your information will be kept safe at every step of the process. *This form follows HIPAA compliancy rules to ensure the security of your information.*

# LastingSmiles

DENTAL CARE

## PATIENT INFORMATION

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL # \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ IF F/T STUDENT, SCHOOL NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

DENTAL INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY WHO DOES NOT LIVE WITH YOU:

NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

## FAMILY INFORMATION

### HUSBAND (OR FATHER IF MINOR)

### WIFE (OR MOTHER IF MINOR)

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ BUSINESS PHONE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

DENTAL INSURANCE CO. \_\_\_\_\_ SS # \_\_\_\_\_

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ BUSINESS PHONE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

DENTAL INSURANCE CO. \_\_\_\_\_ SS # \_\_\_\_\_

## AUTHORIZATION

I authorize Dr. Ghodsi and his staff to perform any diagnostic procedures and treatment deemed appropriate for proper dental care. I authorize the release of any information concerning my or my dependents health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits and/or other dentist.

I hereby authorize payment of insurance benefits directly to Dr. Ghodsi or his associates. I understand and agree, that regardless of my insurance status, I am ultimately responsible for the balance of my account for any dental services provided.

I understand that all responsibility for payment of dental services provided for myself or my dependents is mine, due and payable at the time services are rendered unless prior arrangements have been made. I also understand that if I do not pay the entire balance within 60 days, a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.

X \_\_\_\_\_ Date \_\_\_\_\_

Adult Patient  Father (Or Husband)  Mother (Or Wife)  Guardian

# DENTAL HISTORY

Patient Name \_\_\_\_\_

**Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.**

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Previous Dentist's Name \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold? Yes No  
Sweets? Yes No  
Biting or Chewing? Yes No

If Yes, Where? \_\_\_\_\_

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters, or any other oral lesions? Yes No

Do your gums bleed or hurt Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If Yes, Where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite you lips or cheeks regularly? Yes No

Mouth breath while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke or chew tobacco? Yes No

**Have you ever had:**

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bit adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

**Are you:**

Satisfied with your teeth's appearance? Yes No

Nervous about having dental treatment? Yes No

Have you ever had an upsetting dental experience? Yes No

Is there anything special you would like us to know that would make your visit as pleasant as possible?

If yes, please describe \_\_\_\_\_

History Review

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

