

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____

HOW OFTEN DID YOU VISIT BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

Do your gums bleed while brushing or flossing.....yes no

Are your teeth sensitive to hot or cold Liquids/foods.....yes no

Do you feel pain in any of your teeth.....yes no

Do you have any sores or lumps in or near your mouth.....yes no

Have you had any head, neck or jaw injuries.....yes no

Have you ever experienced any of the following problems in your jaw:

Clicking.....yes no

Painyes no

Difficulty in opening or closing..yes no

Difficulty in chewing.....yes no

Do you have frequent headaches.....yes no

Do you clench or grind your teeth.....yes no

Do you bite your lips or cheeks frequency..... yes no

Have you noticed any loosening of your teeth.....yes no

Does food tend to become caught between your teeth.....yes no

Have you ever had periodontal treatment gums.....yes no

Ever worn a bite plate or other appliance.....yes no

Have you ever had any difficult extractions in the past.....yes no

Have you ever had any prolonged bleeding following extractions.....yes no

Do you wear dentures or partials.....yes no

If yes, date of placement _____

Have you ever received oral hygiene instructions regarding the care of your teeth or gums.....yes no

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

X _____ DATE _____
Signature of patient or parent (if minor)

X _____ DATE _____
Signature of Dentist