PATIENT DENTAL HISTORY

Please note that prior to any treatment our office requires a complete medical and dental history. Knowing any health problems that you have and/or medications thatyou may be taking can avoid problems when treatment commences. Thanks for taking the time to answer these questions

PATIENT'S NAME ______________________ DATE OF BIRTH______________

REASON FOR THIS VISIT ______________________

WHEN WAS YOUR LAST DENTAL VISIT? WHAT WAS DONE THEN? ______________________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN? ______________________

PREVIOUS DENTIST (NAME AND LOCATION) ______________________

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN? IF SO, WHEN? ______________________

HOW OFTEN DO YOU BRUSH AND / OR FLOSS YOUR TEETH? ______________________

IS YOUR DRINKING WATER FLUORIDATED? ______________________

Question	Y	N
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ...	Y	N
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?..........	Y	N
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?..........	Y	N
4. DO YOU FEEL PAIN WITH ANY OF YOUR TEETH?..........	Y	N
5. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?........	Y	N
6. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	Y	N
7. HAVE YOU HAD ANY HEAD,NECK, OR JAW INJURIES?	Y	N
8. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING		
PROBLEMS WITH YOUR JAW?..........	Y	N
CLICKING OR GRINDING NOISES..........	Y	N
PAIN (JOINT, EAR, SIDE OF FACE)	Y	N
DIFFICULTY IN OPENING OR CLOSING	Y	N
DIFFICULTY IN CHEWING	Y	N
9. DO YOU HAVE FREQUENT HEADACHES?	Y	N
10. DO YOU CLENCH OR GRIND YOUR TEETH?..........	Y	N
11. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?............	Y	N
12. HAVE YOU NOTICED ANY TEETH BECOMING LOOSE?............	Y	N
13. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	Y	N
14. HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT?	Y	N
15. HAVE YOU EVER WORN A BITE PLATE, NIGHTGUARD OR OTHER APPLIANCE?	Y	N
16. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	Y	N
17. HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	Y	N
18. DO YOU WEAR FULL OR PARTIAL DENTURES?....... IF YES, DATE OF PLACEMENT ______________	Y	N
19. HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	Y	N

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 PAYORS AND/OR HEALTH PRACTITIONERS. 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 OR MY DEPENDENTS.

DATE SIGNATURE OF PATIENT OR PARENT IF MINOR

DOCTOR'S COMMENTS SIGNATURE Date