PATIENTS DENTAL HISTORY

PATIENT NAME _____ **BIRTH DATE** _____

REASON FOR THIS VISIT_____
WHEN WAS YOUR LAST DENTAL VISIT_____**WHAT WAS COMPLETED**_____
HOW OFTEN DID YOU VISIT THE DENTAL OFFICE BEFORE THEN_____
PREVIOUS DENTISTS NAME & LOCATION_____
HAVE YOU HAD A COMPLETE SERIES OF X-RAYS TAKEN, IF SO, WHEN/WHERE_____
HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ **HOW OFTEN DO YOU FLOSS?** _____
IS YOUR DRINKING WATER FLUORIDATED? _____

YES OR NO

DO YOUR GUMS BLEED WHILE BRUSHING	**DO YOU BITE YOUR LIPS/CHEEKS?** _____
OR FLOSSING? ____	**LOOSENING OF TEETH?** _____
SENSITIVE TO SWEET OR SOUR	**DOES FOOD TEND TO BECOME CAUGHT**
LIQUIDS/FOODS? _____	**BETWEEN YOUR TEETH?** _____
FEELING ANY PAIN ON ANY TEETH? _____	**HAVE YOU HAD PERIODONTAL TREATMENT**
DO YOU HAVE ANY SORES/LUMPS IN OR	**(TREATMENT ON YOUR GUMS)** _____
NEAR YOUR MOUTH? _____	**EVER WORN A BITE PLATE OR ANY OTHER**
HAVE YOU HAD ANY NECK, HEAD, OR JAW	**APPLIANCE?** _____
INJURIES? _____	**HAVE YOU HAD DIFFICULT EXTRACTIONS IN**
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING	**THE PAST?** _____
PROBLEMS IN YOUR JAW:	**HAD ANY PROLONGED BLEEDING FOLLOWING**
CLICKING _____	**EXTRACTIONS?** _____
PAIN (JOINT, EAR, SIDE OF FACE) _____	**DO YOU WEAR DENTURES/PARTIALS?** _____
DIFFICULTY OPENING OR CLOSING _____	**IF YES, DATE OF PLACEMENT?** _____
DIFFICULTY IN CHEWING _____	**HAVE YOU RECEIVED ORAL HYGIENE**
DO YOU HAVE FREQUENT HEADACHES? _____	**INSTRUCTIONS REGARDING CARING FOR**
DO YOU CLENCH OR GRIND YOUR TEETH? _____	**GUMS & TEETH?** _____

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, BRIEFLY DESCRIBE WHAT YOU WOULD 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 ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE AND THIRD PARTY PAYORS 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, OR MY DEPENDANTS.

<u>X</u>_____ **DATE:** _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OF MINOR