

Patient Dental History

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 exams (x-rays) taken? When and where _____

How often do you brush your teeth _____ How often do you floss your teeth _____

Is your drinking water fluoridated _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| Do your gums bleed while brushing or flossing _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to hot or cold liquids/foods _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to sweet or sour liquids/foods _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel pain to any of your teeth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any sores or lumps in or near your mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any head, neck, or jaw injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever experienced any of the following problems in your jaw? | | |
| Clicking _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you clench or grind your teeth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bite your lips or cheeks frequently _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|--|--------------------------|--------------------------|
| Have you noticed any loosening of your teeth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does food tend to become caught between your teeth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had periodontal treatment (gums) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever worn a bite plate or other appliance _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any difficult extractions in the past _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any prolonged bleeding following extractions _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear dentures or partials _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of placement _____ | | |
| Have you ever received oral hygiene instructions regarding the care of your teeth and gums _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had ortho/braces in the past _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you be interested in teeth whitening _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had an unfavorable dental experience _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you snore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have sleep apnea? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

If you could change anything about your smile, what would you change? _____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 2 working day notice. Once an appointment is made, please remember this time has been reserved for you.

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 my 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 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 dependents.

X _____ Date _____

Signature of patient or parent if minor

Doctor's Comments _____

Signature _____ Date _____

Patient Number