Dental History

East Dental Family Dentistry

Patient Name (please print) **Date of Birth:** **Date:**

Reason for this visit

When was your last dental visit? **What was done?**

How often did you visit the dentist then?

Previous Dentist (name & city/state) **Contact phone number:**

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?

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquds/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in our near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you ever had periodontal treatment (gums)?	☐	☐
Ever worn a bite plate or other appliance?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, when were they placed?		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

If you could change <u>ANYTHING</u> 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 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.

Signature of patient or parent/guardian/caregiver