

Dental History

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)

Phone number:

Have you had dental films taken?

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 cold temperatures?	<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 spontaneous moderate pain in your teeth or pain to hot temperatures?	<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 or Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing or 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"/>
Have you noticed any loosening or new gaps 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 (gum) treatment (deep cleaning)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever worn a bite plate, splint or Nightguard?	<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 dental work or are you on blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what year were they last made?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

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 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