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 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 FREQUENTLY OR FLOSSING.....	___	___
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	___	___
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	___	___
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	___	___
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	___	___
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES IN THE PAST.....	___	___
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING.....	___	___
PAIN (JOINT, EAR, SIDE OF FACE).....	___	___
DIFFICULTY IN OPENING OR CLOSING.....	___	___
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		
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	___	___
DO YOU WEAR DENTURES OR PARTIALS.....	___	___
IF YES, DATE OF PLACEMENT_____		
HAVE YOU EVER RECEIVED ORAL HYGIENE		

DIFFICULTY IN CHEWING..... ___ ___

DO YOU HAVE FREQUENT HEADACHES..... ___ ___

DO YOU CLENCH OR GRIND YOUR TEETH..... ___ ___

INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS..... ___ ___

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

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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 DANGERSOUS 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 RENDERED ON MY BEHALF OR MY DEPENDENTS.

X

SIGNATURE_____DATE_____

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