PATIENT'S DENTAL HISTORY

*PATIENT'S NAME*_____*DATE OF BIRTH*_____

REASON FOR THIS VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT_____WHAT WAS DONE THEN_____

PREVIOUS DENTIST (NAME & 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 OR FLOSSING……	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD 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……	☐	☐
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……..	☐	☐

	YES	NO
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH……	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)……	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST……	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS……..	☐	☐
DO YOU WEAR DENTURES OR PARITALS……	☐	☐
IF YES, DATE OF PLACEMENT_____		
DO YOU OWN A C-PAP MACHINE…….	☐	☐
IF SO, DO YOU USE IT……	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
IF SO, WHICH APPLIANCE DO YOU HAVE:		
NIGHTGUARD……..…	☐	
ORTHOTIC SPLINT……	☐	
SLEEP APNEA (SNORE)……	☐	
DO YOU USE THE ABOVE APPLIANCE……..	☐	☐
DO YOU FEEL FATIGUED DURING THE DAY……	☐	☐
DO YOU SLEEP WELL AT NIGHT	☐	☐

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. ALL QUESTIONS HAVE BEEN ACCURATELY ANSWERED, I UNDERSTAND PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND 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 PRENT/GUARDIAN