PATIENT DENTAL HISTORY

Name of Previous Dentist ______________________________ Date of Last Exam ______________________________
Location____ Office Phone__________________________________

	Yes	No
1. Do you medicate with antibiotic for dental treatment	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth Sensitive?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems with your jaw?	☐	☐
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening, closing or chewing?	☐	☐
8. Do you have frequent Headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you have dental implants?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _________________________		
15. Do you like your smile?	☐	☐
16. Do you have any major dental complaints or problems?	☐	☐
If yes, what ____		
17. Have you had previous dental treatment that you have not been satisfied with?	☐	☐

____

____

____

18. If yes, how can we make your dental treatment a positive experience?

____

____

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 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 the services. I agree to be responsible for payment of all services rendered on my behalf for my dependents.

X____
Signature of the patient (or parent if minor)

We would appreciate 48 hours notice for appointment cancellations.