PATIENT DENTAL HISTORY

Patient Name: _____DOB:_____/_____/_____

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 & location) _____

Have you had a complete series of dental films (x-rays) taken in the last 5 years? _____

If yes, when? _____/_____/_____where?_____

How often do you brush your teeth?_____How often do you floss your teeth?_____

	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/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 opening or closing	__	__
Difficulty chewing	__	__

	Yes	No
Do you have frequent headaches	__	__
Do you clench/grind you teeth	__	__
Do you bite your lips/cheek 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)	__	__
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	__	__
Do you wear dentures or partials	__	__
If yes, date of placement ___/___/_____		

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 of 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 of dental group insurance benefits otherwise payable to me unless specified differently. 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.

_____Date_____

Signature of patient/parent/guardian of minor

Through posted documentation, I have been informed of this office's notice of privacy practices.

_____Date_____

Signature of patient/parent/guardian of minor