Patient Dental History

Patient's Name ______________________________ Date Of Birth ____________________

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.......	____	____
Are your teeth sensitive to hot or cold liquids/foods.................................	____	____
Are your teeth sensitive to sweet or sour liquids/foods.................................	____	____
Do you feel pain in any of your teeth...	____	____
Do you have any sores or lumps in or around your mouth............................	____	____
Have you ever 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..............................	____	____
Do you have frequent headaches..........	____	____
Do you clench or grind your teeth........	____	____

	YES	NO
Do you bite your lip or cheeks frequently.........	____	____
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 in the past......................................	____	____
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 instructions regarding the care of your teeth and gums..	____	____

If you could change ***anything*** thing 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 and request my insurance 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 parent if minor

Doctor's Comments______________________________

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Signature__________________ Date__________