PAST DENTAL HISTORY

REASON FOR INITIAL VISIT:

LAST DENTAL VISIT:	**LAST DENTAL CLEANING:**	**PREVIOUS DENTIST:**
Date: __________________ (M D Y)	Date: __________________ (M D Y)	

Please check YES or No. If not sure, please check NS.

	NO	NS	YES
Are you suffering from pain now?	☐	☐	☐
Are any of your teeth becoming loose?	☐	☐	☐
Have any of your teeth shifted?	☐	☐	☐
Does your food get caught between your teeth?	☐	☐	☐
Are any teeth sensitive to: cold ☐ hot ☐ biting ☐ pressure ☐ sweet ☐ bitter ☐			
Is there any swelling or pain of your gums?	☐	☐	☐
Is there a history of gum disease in your family?	☐	☐	☐
Are you aware of sores/growths in your mouth?	☐	☐	☐
Do you notice any bleeding from your gums when you brush your teeth, or other?	☐	☐	☐
Have you had a local anesthetic (freezing)?	☐	☐	☐
...any complications?	☐	☐	☐
Have you had any teeth extracted?	☐	☐	☐
...any complications?	☐	☐	☐
Do you have burning sensation of lips or tongue?	☐	☐	☐
Does your mouth tend to get dry?	☐	☐	☐
Do you have a bad taste in your mouth or bad breath?	☐	☐	☐
Are you nervous about having dental treatment?	☐	☐	☐
Have you ever had an upsetting experience in a Dental office?	☐	☐	☐

EXPLAIN:

HABITS Do you -	NO	NS	YES
Clench or grind your teeth while asleep?	☐	☐	☐
Bite your lips or cheeks regularly?	☐	☐	☐
Hold foreign objects with your teeth such as pencils, pipe, pins, nails, fingernails?	☐	☐	☐
Breathe through your mouth while awake or asleep?	☐	☐	☐

	NO	NS	YES
Do you use Dental aids?	☐	☐	☐
Do you use any flouride/mouth rinses?	☐	☐	☐
Are you happy with the appearence of your teeth?	☐	☐	☐
What would you like to change about your teeth?	☐	☐	☐
How often do you brush your teeth?	☐	☐	☐
How often do you floss your teeth?	☐	☐	☐

JAW PROBLEMS Do you have any of the following?	NO	NS	YES
Clicking/popping of jaw when opening/closing?	☐	☐	☐
Pain (in jaw joints, ear, side of face)?	☐	☐	☐
Difficulty in opening or closing your mouth?	☐	☐	☐
Pain and/or difficulty in chewing?	☐	☐	☐
Pain when cleaning your teeth?	☐	☐	☐
Have you ever had implant surgery in one or both of your jaw joints?	☐	☐	☐
If yes, who performed the surgery and when was it done?	☐	☐	☐
Are you being followed-up by a dental specialist?	☐	☐	☐

TREATMENTS Please check off the following treatments you have had:	NO	NS	YES
Orthodontic treatment (braces) ?	☐	☐	☐
Oral Surgery?	☐	☐	☐
Periodontal treatment (gum surgery) ?	☐	☐	☐
Teeth ground or bite adjustment?	☐	☐	☐
Worn a bite plate or other appliance?	☐	☐	☐
Dental implants?	☐	☐	☐

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic proceedures and treatment, including general or local anesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be inclusive. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that your office can collect, use and disclose personal information about me as set out in your office privacy policy.

Patient ☐ Parent ☐ Guardian ☐ POA ☐ Date: ____________ Signature: ____________________