DENTAL HISTORY – ADULT

OOSTBURG FAMILY DENTISTRY
DANIEL R. BRUHN, D.D.S.
JORDAN D. MOLTER, D.D.S.

Today's Date:

PATIENT INFORMATION

Last Name:	First:	Middle:
Date of Birth:	Age:	Sex: ❒ M ❒ F

DENTAL HISTORY

Purpose of today's visit:

Date and purpose of last dental visit:

Name of previous dentist: City:

Have you had dental x-rays in the last 12 months? **Yes** **No**

Are you aware of any dental problems? **Yes** **No**

Do you see a dentist regularly? **Yes** **No**

Are you happy with the general condition of your teeth? **Yes** **No**

Are you happy with the appearance of your teeth? **Yes** **No**

How often do you brush your teeth?

How often do you floss your teeth?

Is there anything about dentistry that you strongly dislike?

Do you have any questions or concerns?

Please check all that you have had:

- ❒ teeth sensitive to hot
- ❒ teeth sensitive to cold
- ❒ teeth sensitive to sweets
- ❒ teeth sensitive to pressure
- ❒ teeth sensitive to chewing
- ❒ clenching or grinding your teeth
- ❒ jaw that clicks or pops
- ❒ frequent headache or neck pain
- ❒ pain/soreness in the muscle around the ear
- ❒ chronic bad breath
- ❒ bleeding gums when you brush/floss
- ❒ complications from tooth removal

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance. I authorize Oostburg Family Dentistry and my insurance company to release any information required to process my claims.

______________________________ ____________________

Patient or Guardian Signature Date