DENTAL HISTORY

Name _____ Date _____

Reason for visit? _____

General Dentist Name _____ How Long? _____

Do you have pain in any area of your mouth today? _____

Last dental cleaning? _____ Last X-Rays? _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Does food tend to become caught between your teeth? . . . Yes No

If yes, where? _____

Periodontal (Gum) treatment? . . . . . Yes No

Orthodontic treatment (braces)? . . . . . Yes No

Oral surgery? . . . . . Yes No

Your teeth ground or the bite adjusted? . . . . . Yes No

A bite plate or mouth guard? . . . . . Yes No

Do your gums bleed or hurt? . . . . . Yes No

Have your parents experienced gum disease/tooth loss? . Yes No

Have you noticed any loss teeth or change in your bite? . . Yes No

Are any of your teeth sensitive to hot, cold or sweets? . . . . Yes No

Have you noticed any mouth odors or bad taste? . . . . . Yes No

Is there anything else about having dental treatment that you would like us to know? . . . . . Yes No

If yes, what? _____

Do you frequently get cold sores, blisters or any other oral lesions? . . . . . Yes No

Do you clench or grind your teeth while awake/asleep? . Yes No

Do you get frequent headaches? . . . . . Yes No

Do you have pain around the ears? . . . . . Yes No

Do your jaws ever hurt or feel tired? . . . . . Yes No

Do you have any mouth habits? . . . . . Yes No

Do you mouth breath while awake or asleep? . . . . . Yes No

Are you satisfied with your teeth's appearance? . . . . . Yes No

Would you like to keep all of your teeth all of your life? . Yes No

Do you feel nervous about having dental treatment? . . . Yes No

Is so, what is your biggest concern _____

_____

_____

A serious injury to the mouth or head? . . . . . Yes No

Is so, please describe, including cause. _____

_____

Have you ever had an upsetting dental experience? . . . Yes No

Is so, please describe _____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance.

PATIENT Signature (Parent or Guardian of Child) _____ Date: _____

DENTAL HISTORY REVIEW
