DENTAL HISTORY

Please ✓ YES or NO to each question. If unsure of a question, please consult with your dentist.

Is there a dental problem you would like treated immediately Yes ❑ No ❑ ____________________

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Date of your last dental visit? __________ Last dental cleaning? __________ Last X-Rays? __________

		YES	NO
1.	Have you been seeing a dentist regularly?	❑	❑
2.	Have you ever had any of the following:		
	- Periodontal Treatment? (treatment of the gums)	❑	❑
	- Orthodontic Treatment? (to straighten or realign teeth)	❑	❑
	- A bite plate or any other appliance?	❑	❑
	- Your bite adjusted or teeth ground?	❑	❑
	- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	❑	❑
	If you answered "yes" to the last question, who performed the surgery? __________ When? __________		
	Are you being followed-up by a dental specialist?	❑	❑
3.	Are there any growths or sore spots in your mouth?	❑	❑
4.	Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of the gums?	❑	❑
5.	Have you noticed any loose teeth, or, have any of your teeth shifted?	❑	❑
6.	Does food catch between your teeth?	❑	❑
7.	Are any of your teeth sensitive to heat, cold, sweets or pressure?	❑	❑
8.	Have you been advised to take antibiotics before a dental appointment?	❑	❑
9.	Do you use dental floss, proxabrush or stimudents? How often?	❑	❑
10.	How often do you brush your teeth? __________ Do you feel that you have bad breath?	❑	❑
11.	Have your ever experienced any of the following jaw problems?		
	- Popping/clicking in your jaw joints?	❑	❑
	- Pain in your jaw joints, around your ear, or side of your face?	❑	❑
	- Difficulty in opening or closing?	❑	❑
	- Pain when teeth are clenched?	❑	❑
	- Pain or difficulty while chewing?	❑	❑
12.	Do you have any of the following habits?		
	- Clenching or grinding your teeth while awake or asleep?	❑	❑
	- Biting your cheeks or lips?	❑	❑
	- Mouth breathing while awake or asleep?	❑	❑
	- Placing foreign objects in your mouth? (pencils, nails, pipes, pins, fingernails?)	❑	❑
13.	Do you have any emotional concerns about having dental treatment?	❑	❑
14.	Are you unhappy with the appearance of your teeth?	❑	❑
	and, What would you like to see changed?		

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GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine the necessary treatment. I understand that information provided from or to my medical doctor or another heath care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with those services.

X ______________________________ ______________________________

(Signature) Patient ❑ Parent ❑ Guardian ❑ Print Name of Guardian)

Reviewed by Treating Dentist: ______________________________ Date: __________