

## Patient Dental History

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's date \_\_\_\_\_

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Reason for this visit: \_\_\_\_\_

Approximate date of last dental visit: \_\_\_\_\_

Previous dentist's name and location (optional) \_\_\_\_\_

Have you had a recent (within 2 years) complete series of dental x-rays taken? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

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Do your gums bleed while brushing or flossing?

Are your teeth sensitive to hot /cold/liquids/foods/sweets?

Do you feel pain in any of your teeth?

Do you have any sores or lumps in or near your mouth?

Have you ever experienced any of the following problems in your jaw:

Clicking

Difficulty opening or closing

Pain (joint, ear, side of face)

Teeth sensitive to biting pressure

Do you clench or grind your teeth?

Do you bite your lips or cheeks frequently?

Do you have frequent cold sores or mouth ulcers?

Have you noticed a bad taste or do you suspect bad breath?

Have you noticed a loosening of your teeth?

Does food tend to become caught in your teeth?

Do you have trouble flossing?

Have you ever had periodontal treatment for gum disease?

Have you ever worn a bite guard or other appliance?

Have you ever had any difficult extractions in the past?

Have you ever had any prolonged bleeding following extraction?

Do you have a problem with dry mouth?

Do you use an electric tooth brush?

Would you like to receive instructions regarding the care of your teeth and gums?

Is there any dental concern you wish to discuss? \_\_\_\_\_

If you could change anything about your smile, what would you change?

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Are you satisfied with the appearance of your teeth? \_\_\_\_

Have you considered bleaching to whiten your teeth? \_\_\_\_

Are you interested in improving the appearance of you smile? \_\_\_\_\_

### **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 the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to me. I understand than my dental insurance carrier my pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: \_\_\_\_\_