Patient Dental History

Name of Previous Dentist_____ Date of Last Exam_____

Previous Dentist's Location_____ Date of Last Cleaning_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	_____	_____
2. Are your teeth sensitive to hot or cold liquids/foods?	_____	_____
3. Are your teeth sensitive to sweet or sour liquids/foods?	_____	_____
4. Do you feel pain to any of your teeth?	_____	_____
5. Do you have any sores or lumps in or near your mouth?	_____	_____
6. Have you had any head, neck or jaw injuries?	_____	_____
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	_____	_____
Pain (joint, ear, side of face)	_____	_____
Difficulty in opening or closing	_____	_____
Difficulty in chewing	_____	_____
8. Do you have frequent headaches?	_____	_____
9. Do you clench or grind your teeth?	_____	_____
10. Do you bite your lips or cheeks frequently?	_____	_____
11. Have you ever had any difficult extractions in the past?	_____	_____
12. Have you ever had any prolonged bleeding following extractions?	_____	_____
13. Have you had any orthodontic treatment?	_____	_____
14. Do you wear dentures or partials?	_____	_____
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	_____	_____
16. Do you like your 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 the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or parent/guardian if minor) Print name of patient