Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Visit_____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot/cold liquids/food?	❑	❑
3. Are your teeth sensitive to sweet/sour liquid/food?	❑	❑
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 ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain	❑	❑
Difficulty in opening/closing?	❑	❑
Difficulty in chewing?	❑	❑
7. Have you ever had any head, neck or jaw injuries?	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips/cheeks often?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding from extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials?	❑	❑
15. Have you received oral hygiene?	❑	❑
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 answered accurately. 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 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.

_____ _____

Signature of Patient *(or parent or guardian if a minor)* Date

Doctor's Comments_____

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Signature_____ Date_____