Patient Dental History

Today's Date:

Patients Name

Title *First* *Middle* *Last*

Birth Date

Reason for this visit

When was last dental visit?

What did you have done?

How often did you visit the dentist before?

Previous dentist name, location?

Have you had a complete series of xrays taken?

How often do you brush?

How often do you floss?

Drinking water fluorinated?

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Check all that apply

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquid/food?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you ever had periodical treatment (gums)?	☐	☐
Ever worn a bite plate or other appliance?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding follow extraction?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement		
Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	☐	☐
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	☐	☐
Do you have frequent headaches?	☐	☐

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

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 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 dependants.

Signature of patiend or parent/guardian if minor.
X____

Doctor's Signature ____

Comments: ____

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Date: ____