Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe _____

Have you ever had trouble with a previous dental treatment? ☐Yes ☐No

If so, please describe _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone _____

Why are you changing dentists? _____

How often do you have a dental examination? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Soft ☐ Medium ☐ Hard

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐Yes	☐ No	Do you have frequent headaches?	☐Yes	☐ No
Do your gums ever bleed?	☐Yes	☐ No	Do you clench or grind your teeth?	☐Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐Yes	☐ No	Are your teeth sensitive to heat/cold?	☐Yes	☐ No
Do you bite your lips or cheeks frequently?	☐Yes	☐ No	Do you still have your wisdom teeth?	☐Yes	☐ No
Periodontal disease/gum treatment	☐Yes	☐ No	Discomfort in your jaw joint (IMJ/IMU)	☐Yes	☐ No
Orthodontics treatment	☐Yes	☐ No	Your teeth ground or bite adjusted	☐Yes	☐ No
Oral surgery	☐Yes	☐ No	Serious injury to the mouth or head	☐Yes	☐ No

If yes to any of the previous questions, please describe _____

Payment is due in full at the time of treatment unless prior arrangements have been approved

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or deductible that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ *Date* _____

Person to contact in case of emergency Relationship _____

Name _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN

DATE: _____INITIALS_____