Patient Dental History

1. How long since your last dental visit? ____________
2. What was done at that visit? ____________
3. Purpose of this visit? ____________

	Yes	No
4. Do your gums bleed or hurt?	❒	❒
5. Are your teeth sensitive to: Hot?	❒	❒
Cold?	❒	❒
Sweets?	❒	❒
Biting Pressure?	❒	❒
6. Do you feel pain to any of your teeth?	❒	❒
7. Do you have any sores or lumps in or near your mouth?	❒	❒
8. Have you had any head, neck or jaw injuries?	❒	❒
9. Have you ever experienced any of the following problems in your jaw:		
a: Clicking or popping?	❒	❒
b: Pain (joint,ear, side of face)?	❒	❒
c: Difficulty in opening or closing?	❒	❒
d: Difficulty in chewing?	❒	❒
10. Do you have frequent headaches?	❒	❒
11. Do you clench or grind your teeth?	❒	❒
12. Does food get caught between your teeth?	❒	❒
13. Have you ever had any difficult extractions?	❒	❒
14. Have you ever had any prolonged bleeding following extractions?	❒	❒
15. Have you ever had any orthodontic (braces) work?	❒	❒
16. Have you ever had periodontal (gums) work?	❒	❒
17. Have you ever had instruction on the correct method of caring for your teeth and gums?	❒	❒

18. How often do you brush? ____________
19. How often do you floss? ____________
20. What other dental aids do you use? (proxybrush, toothpicks) ____________
21. Please rate your teeth from one to ten. Ten being the best. ____________
22. What did you like or dislike about your past dental expreiences? ____________

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23. What do you expect of us as your dental office? ____________

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24. Why did you choose not to have dental work done in the past?
    a: time
    b: cost
    c: pain
    d: fear

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 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 period of such dental care to third party payors and/or health paractitioners.

Signature ____________ Date ____________