

DENTAL HISTORY

Please YES or NO to each question. If unsure of a question, please consult with the dentist.

Is there a dental problem you would like treated immediately? Yes No _____

YES NO

Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____

1. Have you been seeing a dentist regularly? _____

2. Have you ever had any of the following? _____

- Periodontal Treatment? (treatment of the gums) _____

- Orthodontic Treatment? (to straighten or realign teeth) _____

- A bite plate or any other appliance? _____

- Your bite adjusted or teeth ground? _____

- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) _____

If you answered "yes" to the last question, who performed the surgery? _____ When? _____

Are you being followed up by a dental specialist? _____

3. Are there any growths or sore spots in your mouth? _____

4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____

5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____

6. Does food catch between your teeth? _____

7. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____

8. Have you been advised to take antibiotics before a dental appointment? _____

9. Do you use dental floss, proxabrush or stimulents? How often? _____

10. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____

11. Have you ever experienced any of the following jaw problems: _____

- Popping/clicking in your jaw joints? _____

- Pain in your jaw joints, around your ear, or side of your face? _____

- Difficulty in opening or closing? _____

- Pain when teeth are clenched? _____

- Pain or difficulty while chewing? _____

12. Do you have any of the following habits? _____

- Clenching or grinding your teeth while awake or asleep? _____

- Biting your cheeks or lips? _____

- Mouth breathing while awake or asleep? _____

- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____

13. Do you have any emotional concerns about having dental treatment? _____

14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____

15. Are you unhappy with the appearance of your teeth? _____

and, What would you like to see changed? _____

16. Do you feel your dental health influences your overall health? _____

17. On a scale of 1 to 10, 10 being highest, how important is it for you to keep your natural teeth? _____

GENERAL RELEASE (Please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____
(signature) Patient Parent Guardian

(print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____