

# DENTAL HISTORY

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

Is there a dental problem you would like treated immediately Yes  No  \_\_\_\_\_

Date of your last dental visit? \_\_\_\_\_ Last dental cleaning? \_\_\_\_\_ Last X-Rays? \_\_\_\_\_ YES NO

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 the 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. Are you unhappy with the appearance of your teeth? \_\_\_\_\_

and, What would you like to see changed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental-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 my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine the necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. 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 those services.

X \_\_\_\_\_  
 (Signature) Patient  Parent  Guardian  \_\_\_\_\_ Print Name of Guardian)

Reviewed by Treating Dentist: \_\_\_\_\_ Date: \_\_\_\_\_