

Dental History

Patient Name: _____

Date: _____

What is the reason for your appointment today? _____
Are you in any dental discomfort? _____
Who is your former dentist? _____ Phone _____
What is the date of your last dental care? _____ Date of last x-rays? _____
Are you happy with your smile? _____
Is there anything about your smile that you would like to change? _____

Do you have a problem with any of the following?

Bad Breath	<input type="radio"/> Yes	<input type="radio"/> No
Bleeding Gums	<input type="radio"/> Yes	<input type="radio"/> No
Clicking or popping jaw	<input type="radio"/> Yes	<input type="radio"/> No
Food collection between teeth	<input type="radio"/> Yes	<input type="radio"/> No
Grinding or clenching teeth	<input type="radio"/> Yes	<input type="radio"/> No
Periodontal treatment	<input type="radio"/> Yes	<input type="radio"/> No
Adverse reaction to dental or medical care	<input type="radio"/> Yes	<input type="radio"/> No

Sensitivity to hot	<input type="radio"/> Yes	<input type="radio"/> No
Sensitivity to cold	<input type="radio"/> Yes	<input type="radio"/> No
Sensitivity when biting	<input type="radio"/> Yes	<input type="radio"/> No
Sensitivity to sweets	<input type="radio"/> Yes	<input type="radio"/> No
Loose teeth or broken fillings	<input type="radio"/> Yes	<input type="radio"/> No
Sores or growth in mouth	<input type="radio"/> Yes	<input type="radio"/> No
Other: _____		

Please list all of your current medications:

_____ I am not currently taking any medications

PLEASE SIGN AND DATE THE FOLLOWING:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient, parent or guardian

Date