

PATIENT DENTAL HISTORY

How often do you visit the dentist?

- Twice a Year Check Ups
- Annual Check Ups
- Only when I have a problem
- Other _____

Have you ever had any of the following?

| | No | Yes | | No | Yes |
|-------------------------------------|----|-----|------------------------------|----|-----|
| Braces | | | Gum Disease | | |
| Periodontal (Gum) Treatments | | | Root Canal Treatment | | |
| Oral Surgery or Extractions | | | Serious Injury to Mouth | | |
| Crowns or Bridges | | | Extensive Dental Procedures | | |
| Dental Implants | | | Dentures or Partial Dentures | | |
| Excessive Bleeding After Extraction | | | Teeth Whitening | | |

Please indicate if you CURRENTLY have any of the following?

| | No | Yes | | No | Yes |
|-----------------------------------|----|-----|---|----|-----|
| Loose teeth? | | | Broken Fillings? | | |
| Dry Mouth? | | | Clicking or Popping When You Open Your Mouth? | | |
| Chew on One Side of Mouth? | | | Fingernail Biting? | | |
| Grinding or Clenching Your Teeth? | | | Jaw Pain or Tiredness? | | |
| Pain During Chewing? | | | Mouth Breathing? | | |
| Does your jaw ever get "stuck"? | | | Headaches or neck pains? | | |
| Uncomfortable bite? | | | Pain Around Your Ear? | | |
| Bleeding Gums? | | | Swollen or Tender Gums? | | |
| Broken or Worn Teeth | | | Tooth Ache | | |
| Bad Breath? | | | Mouth Sores or Growths? | | |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of the office, responsible for any errors or omissions that I may have made in completion of this form. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of changes in my health and medication.

I authorize the use of my radiographs (x-rays) and/or photographs for educational and promotional use in seminars, publications and the dental office website.

Yes No

Patient or Guardian Signature

Date:

X _____

Dentist's Signature:

Date:

DOCTOR'S USE ONLY

Dental management considerations: