Dental History

Date of Last Dental Visit:_____
Oral Cancer Screening:_____
Complete X-rays:_____

Name of Previous Dentist:

_____

Why did you leave your previous dental office?

_____

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

_____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain or clicking
- ☐ Teeth or fillings breaking
- ☐ Bleeding, swollen or irritated gums
- ☐ Grinding or clenching
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Swelling of lips and tongue
- ☐ Discolored lips, cheek, tongue
- ☐ Dry Mouth
- ☐ Discolored teeth
- ☐ Missing teeth

On a Scale of 1-10, with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Do you smoke, vape or use chewing tobacco? How much? For how long?

_____

_____

If you could change your smile, you would:

- ☐ Make them whiter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Have you ever had a reaction to dental anesthetic?

- ☐ Yes
- ☐ No

I, the undersigned, verify that the above information is correct to the best of my knowledge.

Patient/ Guardian Signature _____ Date _____

Consent to Proceed

I authorize Dr. Robison and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as a cleaning and basic dentistry including fillings and all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician of hospital may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature:_____**Date:**_____

(Patient, legal guardian or authorized agent of patient)