Dental History

DATE OF LAST DENTAL EXAM	DATE OF LAST FULL MOUTH XRAY	WHERE TAKEN

	YES	NO
1. Have you had trouble from previous dental care?	☐	☐
2. Do you have pain in your jaw or near your ears?	☐	☐
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
4. Have you experienced any growths or sore spots in your mouth?	☐	☐
5. Does any part of your mouth hurt when clenched?	☐	☐
6. Have you ever had Novocaine or other local anesthetics?	☐	☐
7. Have you ever had Nitrous Oxide (laughing gas)?	☐	☐
8. Have you ever had general anesthesia?	☐	☐
9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
12. Do your gums bleed?	☐	☐
13. Do you have a bad taste in your mouth or mouth odor?	☐	☐
14. Have you ever had instructions on the care of your gums?	☐	☐
15. Do you chew on only on side of your mouth? If so why?	☐	☐
16. Do you habitually clench or grind your teeth during the night or day?	☐	☐
17. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?	☐	☐
18. Do you have any changes in your medical history?	☐	☐

Is there any other problem not covered above that you would like to discuss?

PATIENT SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

I have filled out this health questionnaire completely and I have advised you of all medical problems of which I am aware. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist is responsible for my dental treatment. I understand that I am personally responsible for the cost of my dental care. I agree to pay for any dental work rendered by this office if for any reason whatsoever my insurance coverage denies liability, and I will notify this office of any change in eligibility for insurance coverage. If in default of the above agreement on my part necessitates legal action, I shall assume all responsibility for interest, principal and reasonable attorney's fees.

Signature of patient/parent/guardian____________________ Date:____________

My dental treatment and possible alternatives have been discussed with me. I have been informed of all risks involved with my dental care and local anesthesia, including possible blood loss and infection. I hereby consent to the administration of local anesthesia and the dental treatments specified by the diagnosing doctor.

Signature of Doctor — Date

Signature of Doctor — Date