Patient Dental History

Patient Name:			Today's Date:	
Reasons for today's visit:				
Previous Dentist (Name and Location):				
Last Dental Visit:			Last X-Rays Taken:	
How often do you brush your teeth?			How often do you floss your teeth?	
Type of toothbrush you use? ☐ Automatic ☐ Manual	☐ Hard	☐ Medium	☐ Soft	Type of toothpaste?

Question		
Is your drinking water fluoridated?	☐ Yes	☐ No
Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
Are your teeth sensitive to sweet or sour?	☐ Yes	☐ No
Do you feel pain in any of your teeth?	☐ Yes	☐ No
Do you have any sores/lumps in your mouth/lips?	☐ Yes	☐ No
Have you had any head, neck, or jaw injuries?	☐ Yes	☐ No
Have you experienced any of the following problems with your jaw?		
Clicking? Popping?	☐ Yes ☐ Right ☐ Left	☐ No
Pain (Joint, Ear, or side of Face?)	☐ Yes	☐ No
Difficulty opening or closing your mouth?	☐ Yes	☐ No
Difficulty with chewing?	☐ Yes	☐ No
Do you bite your lips or cheeks?	☐ Yes	☐ No
Have you noticed any loose teeth?	☐ Yes	☐ No
Have you had any previous periodontal (gum disease) treatment?	☐ Yes	☐ No
Have you had any difficulty with extractions in the past?	☐ Yes	☐ No
Have you had any prolonged bleeding after any procedure?	☐ Yes	☐ No
Do you wear dentures or partial dentures? If yes, date of placement?	☐ Yes	☐ No
Do you wear a night guard or an orthodontic appliance?	☐ Yes	☐ No
Have you had previous orthodontic treatment?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had previous tooth whitening treatments?	☐ Yes	☐ No

If yes, what type?	☐ Whitening Strips	☐ Trays at home	☐ 1 hour in office treatment

If you could change anything about your smile, what would it be?

AUTHORIZATION AND RELEASE

I certify that I have read and answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my own or my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered top me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request that my dental insurance company pay directly to the dentist for my dental services. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

X____ ______________________________

Signature of Patient/Guardian Date

X____ ______________________________

Signature of Doctor Date