DENTAL HISTORY

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist.

	YES	NO
Is there a dental problem you would like treated immediately? Yes ☐ No ☐ _____		
_____		
Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____		
1. Have you been seeing a dentist regularly? _____	☐	☐
2. Have you ever had any of the following?		
- Periodontal Treatment? (treatment of the gums) _____	☐	☐
- Orthodontic Treatment? (to straighten or realign teeth) _____	☐	☐
- A bite plate or any other appliance? _____	☐	☐
- Your bite adjusted or teeth ground? _____	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
If you answered "yes" to the last question, who performed the surgery? _____ When? _____		
Are you being followed up by a dental specialist? _____	☐	☐
3. Are there any growths or sore spots in your mouth? _____	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____	☐	☐
6. Does food catch between your teeth? _____	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____	☐	☐
8. Have you been advised to take antibiotics before a dental appointment? _____	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often? _____	☐	☐
10. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____	☐	☐
11. Have you ever experienced any of the following jaw problems:		
- Popping/clicking in your jaw joints? _____	☐	☐
- Pain in your jaw joints, around your ear, or side of your face? _____	☐	☐
- Difficulty in opening or closing? _____	☐	☐
- Pain when teeth are clenched? _____	☐	☐
- Pain or difficulty while chewing? _____	☐	☐
12. Do you have any of the following habits?		
- Clenching or grinding your teeth while awake or asleep? _____	☐	☐
- Biting your cheeks or lips? _____	☐	☐
- Mouth breathing while awake or asleep? _____	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? _____	☐	☐
13. Do you have any emotional concerns about having dental treatment? _____	☐	☐
14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____	☐	☐
15. Are you unhappy with the appearance of your teeth? _____	☐	☐
and, What would you like to see changed? _____		
_____		
16. Do you feel your dental health influences your overall health? _____	☐	☐
17. On a scale of 1 to 10, 10 being highest, how important is it for you to keep your natural teeth? _____		

GENERAL RELEASE (Please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: _____ Date: _____