Patient Medical History

Reason for this visit_____
When was your last dental visit_____ What was done then_____
How often did you visit the dentist before then_____
Previous dentist (name and location)_____
Have you had a complete series of dental exams (x-rays) taken? When and where_____
How often do you brush your teeth_____ How often do you floss your teeth_____
Is your drinking water fluorinated_____

	YES	NO
Do your gums bleed while brushing or flossing_____	□	□
Are your teeth sensitive to hot or cold liquids/foods___	□	□
Are your teeth sensitive to sweet or sour liquids/foods	□	□
Do you feel pain to any of your teeth_____	□	□
Do you have any sores or lumps in or near your mouth___	□	□
Have you had any head, neck or jaw injuries_____	□	□
Have you ever experienced any of the following problems in your jaw?		
Clicking_____	□	□
Pain (joint, ear, side of face)_____	□	□
Difficulty in opening or closing_____	□	□
Difficulty in chewing_____	□	□
Do you have frequent headaches_____	□	□
Do you clench or grind your teeth_____	□	□
Do you bite your lips or cheeks frequently_____	□	□

	YES	NO
Have you noticed any loosening of your teeth_____	□	□
Does food tend to become caught between your teeth___	□	□
Have you ever had periodontal treatment (gums)_____	□	□
Ever worn a bite plate or other appliance_____	□	□
Have you ever had any difficult extractions in the past___	□	□
Have you ever had any prolonged bleeding following Extractions_____	□	□
Do you wear dentures or partials_____	□	□
If yes, date of placement_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums_____	□	□
Have you had ortho/braces in the past_____	□	□
Would you be interested in teeth whitening_____	□	□
Have you ever had an unfavorable dental experience____	□	□

If you could change <u>anything</u> about your smile, what would you change?_____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is Made, please remember this time has been reserved for you.

Authorization and release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and or/health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 dependents.

X_____ Date_____
Signature of patient or parent if minor

Doctor's Comments_____

_____ Signature_____ Date_____