Patient Dental History

Name of Previous Dentist _____ Date of last dental visit _____

Previous Dentist Location _____ Recent X-rays _____

Reason for today's visit _____

Do your gums bleed when brushing or flossing?	Y	N
Are your teeth sensitive to:		
Hot or Cold? Y N Sweet or Sour? Y N Biting Pressure? Y N		
Do you have any sores or lumps in or near your mouth?	Y	N
Have you had any head, neck or jaw injuries?	Y	N
Do you have frequent headaches?	Y	N
Have you experienced any of the following?		
Clicking	Y	N
Pain (joint, ear, side of face)	Y	N
Difficulty in opening or closing	Y	N
Difficulty in chewing	Y	N
Do you clench or grind your teeth?	Y	N
Do you bite your lips or cheeks frequently?	Y	N
Does food collect between your teeth?	Y	N
Do you have dry mouth?	Y	N
Do you use tobacco?	Y	N
Have you ever had any prolonged bleeding following extractions?	Y	N
Have you ever had any trouble associated with previous dental treatment?	Y	N

Circle the type(s) of dental treatment you have experienced:

Orthodontics (braces)	Implants
Oral Surgery	Periodontal (gum) treatment
Dentures	TMJ Treatment
Root Canal Treatment	Fillings

Are you happy with the appearance of your teeth? Y N

If no, please explain _____

Consent

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE Reviewed by Dr. _____ Date _____