DENTAL HISTORY

DATE: ______________________

FULL NAME: ______________________________________________________

PREVIOUS DENTIST: __________________________ CITY: ________________

LAST DENTAL VISIT: ________________ LAST DENTAL XRAYS: ____________

WHY HAVE YOU COME TO THE DENTIST TODAY: ____________________________________________________________

DOES DENTAL TREATMENT MAKE YOU NERVOUS? □ NO □ SLIGHT □ MODERATE □ SEVERE

ARE YOU CURRENTLY IN PAIN? □ YES □ NO IF YES, WHERE? _______________________

YOUR CURRENT DENTAL HEALTH IS: □ GOOD □ FAIR □ POOR

DO YOU LIKE YOUR SMILE? □ IT’S OK □ YES □ NO DO YOUR GUMS BLEED? □ YES □ NO

ARE YOU INTERESTED IN TOOTH WHITENING? □ YES □ NO

HOW MANY TIMES A DAY DO YOU BRUSH: _______/DAY HOW MANY TIMES A WEEK DO YOU FLOSS: _______/WEEK

HOW OFTEN DO YOU USE A FLOURIDE RINSE: _______/WEEK

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

 □ YES □ NO FEVER BLISTERS/COLD SORES □ YES □ NO BURNING TONGUE OR LIPS

 □ YES □ NO CANKER SORES □ YES □ NO SWELLING/LUMPS IN MOUTH

 □ YES □ NO ORTHO TREATMENT (BRACES) - WHAT AGE _______ □ YES □ NO CLICKING/POPPING OF JAW

 □ YES □ NO CLENCHING/GRINDING OF TEETH □ YES □ NO PAIN/DISCOMFORT IN JAW

 □ YES □ NO THUMB/FINGER SUCKING □ YES □ NO MOUTH BREATHING

 □ YES □ NO PROBLEMS SLEEPING □ YES □ NO ALLERGIES

 □ YES □ NO SNORING □ YES □ NO TONGUE THRUST

 □ YES □ NO SORE THROAT □ YES □ NO SPEECH

HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUM DISEASE, PYORRHEA, TRENCH MOUTH)? □ YES □ NO

IF YES, WHEN? ___________________________________________________________

DO YOU HAVE ANY OTHER DENTAL CONDITION THAT WE SHOULD KNOW ABOUT? □ YES □ NO

IF YES, PLEASE EXPLAIN: ______________________________________________________

____________________________________________________________________________

HAVE YOU HAD ANY UNUSUAL DIFFICULTIES WITH THE USE OF DENTAL ANESTHETIC? □ YES □ NO

IF YES, PLEASE EXPLAIN: ______________________________________________________

____________________________________________________________________________

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL STATUS.

I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.

PATIENT (PARENT/GUARDIAN) SIGNATURE: __________________________ DATE: _____________

DOCTOR SIGNATURE: ___________________________________________ DATE: _____________

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.