



## DENTAL HISTORY

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Reason for this visit? \_\_\_\_\_

2. When was your last dental visit? \_\_\_\_\_ Services provided? \_\_\_\_\_

3. Previous Dentist? (name and location) \_\_\_\_\_

4. How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

5. Do you have frequent headaches or migraines?  Yes  No

6. Do you feel pain in your jaw joints?  Yes  No

7. Do you snore or have you been told you snore?  Yes  No

8. Is your drinking water fluoridated?  Yes  No

9. If you could change anything about your smile, what would you change? \_\_\_\_\_

### Have you experienced any of the following?

- Bleeding gums..... Yes  No
- Sensitivity to hot or cold..... Yes  No
- Sensitivity to sweet..... Yes  No
- Pain in any teeth..... Yes  No
- Mouth sores or lumps ..... Yes  No
- Loose teeth..... Yes  No
- Head, neck, jaw injuries..... Yes  No
- Gum treatment/surgery ..... Yes  No
- Oral Surgery..... Yes  No
- Missing teeth..... Yes  No

- Bite lips or cheeks ..... Yes  No
- Clinching or grinding..... Yes  No
- Frequent headaches ..... Yes  No
- Mouth breathing..... Yes  No
- Sleep Apnea..... Yes  No
- Jaw/joint noises ..... Yes  No
- Difficulty opening or closing jaw..... Yes  No
- History of TMJ/Splint Therapy ..... Yes  No
- Previous orthodontic treatment ..... Yes  No
- Food trap..... Yes  No

Emergency contact person: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

### 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 any 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 of 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.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date