DENTAL HISTORY

Name of your previous dentist(s) _____

Office phone number_____Date of your last exam_____

Please answer the following questions:

1.	Do your gums bleed while brushing/flossing?	yes	no
2.	Are your teeth sensitive to hot or cold liquids/foods?	yes	no
3.	Are your teeth sensitive to sweet or sour liquids/foods?	yes	no
4.	Do any of your teeth hurt?	yes	no
5.	Do you have any sores or lumps in or near your mouth?	yes	no
6.	Have you had any head, neck or jaw injuries?	yes	no
7.	Have you ever experienced any of the following: problems in your jaw? or surgeries?		
	Clicking	yes	no
	Pain(joint, ear, side of face)	yes	no
	Difficulty in opening or closing	yes	no
	Difficulty in chewing	yes	no
8.	Do you have frequent headaches?	yes	no
9.	Do you clench or grind your teeth?	yes	no
10.	Do you bite your lips or cheeks frequently	yes	no
11.	Have you had any difficult extractions in the past?	yes	no
12.	Have you ever had prolonged bleeding following extractions?	yes	no
13.	Have you had orthodontic(braces) treatment?	yes	no
14.	Do you wear dentures or partials?	yes	no
	If yes, date of placement_____		
15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	yes	no
16.	Do you like your smile?	yes	no
17.	What would you like to change about your smile?_____		
	_____		
18.	What can we do to help you?_____		
19.	Have you ever whitened or considered whitening your teeth	yes	no

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 in the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers 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.**

Signature of patient (or parent/guardian of minor)_____ Dated_____

Doctor's Comments:_____

Doctor's Signature _____ **Date:** _____