

DENTAL HEALTH HISTORY

Previous Dentist _____ Specialty _____ Phone Number _____

Address _____

Date of last cleaning _____ Last full-mouth x-ray _____ Last dental examination _____

Why are you changing dentist? _____

What are your immediate dental concerns? _____

Have you ever experienced an unfavorable reaction to a dental procedure? _____ If so, please describe _____

Have you ever experienced any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> drifting teeth | <input type="checkbox"/> fever blisters | <input type="checkbox"/> loose teeth |
| <input type="checkbox"/> swelling of gums | <input type="checkbox"/> pain or soreness in gums | <input type="checkbox"/> bad breath or bad taste | <input type="checkbox"/> receding gums |
| <input type="checkbox"/> spaces between teeth | <input type="checkbox"/> food packing between teeth | <input type="checkbox"/> high or rough fillings | <input type="checkbox"/> pus around teeth |

YES NO Have you lost any teeth? From what cause? _____

YES NO Do you have any growths or swelling in your mouth? How long have they existed? _____

YES NO Have you ever been told you have periodontal disease (gum disease)? When? _____

YES NO Are your teeth sensitive to: hot sweet tooth brushing cold biting pressure

YES NO Do you have pain or soreness around your eyes, ears, other parts of your face? _____

YES NO Have you ever been told you grind your teeth during sleep? How often? _____

YES NO Do you have clicking in jaw, popping while eating or yawning or have stiff neck muscles? How often? _____

YES NO Do you have difficulty opening your mouth widely or difficulty swallowing? _____

YES NO Do you have tension headaches? How often? _____ How controlled? _____

YES NO Are you dissatisfied with your teeth and their appearance? _____

YES NO Would you like your teeth to be whiter? _____

YES NO Would you like to know more information on how to enhance your smile? _____

YES NO Have you ever had your teeth straightened? When? _____

YES NO Do any members of your family including your parents, brothers or sisters wear dentures? _____

YES NO Do you want to learn how to control your dental disease and retain your teeth? _____

YES NO Do you get frustrated because you always have something that needs to be treated when you visit a dentist? _____

IF YOU ARE WEARING A PARTIAL OR COMPLETE DENTURE, PLEASE COMPLETE THE FOLLOWING:

How many complete or partial dentures have you had? Upper _____ Lower _____ How long have you worn your present denture? _____

Are you satisfied with the appearance? _____ comfort? _____ chewing ability? _____ speech? _____

I give permission for the use of photographs made in the process of examination and treatment to be used for the purpose of research, education, advertising, promotion, or publication in professional and medical journals.

I give consent and disclosure of my health information to carry out treatment, payment activities, and healthcare operations. If any change occurs in my health, I am to report it to the dental office as soon as possible. If I am unable to keep my appointments and a 24 hour notice is not given, I realize a fee may be charged for the lost time.

I have read, understood and answered all the previous questions truthfully and to the best of my knowledge.

Signature of Patient, Parent or Guardian

Date

Medical Update

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date _____ Exceptions _____ Patient's Signature _____

Date _____ Exceptions _____ Patient's Signature _____

Date _____ Exceptions _____ Patient's Signature _____

Date _____ Exceptions _____ Patient's Signature _____