Dental History

	Circle one			
Are you having any pain or discomfort at this time?	Yes / No			
Your current dental health is:		Good	Fair	Poor
Are you aware of any current dental problems?	Yes / No			
Have you had anitbiotic premedication recommended before dental visits?	Yes / No			
Have you had an adverse reaction to dental treatment or medication in the past?	Yes / No			
Previous Dentist? _____		City: _____		Phone number: _____
Approximate dates of last dental care? _____		Cleaning: _____		Full mouth x-rays: _____
Have you had any injuries to the mouth, teeth, or jaw?	Yes / No			
Are you happy with the appearance of your smile?	Yes / No			
Do you use any form of tobacco?	Yes / No			
Are any teeth sensitive to hot, cold, or sweets?	Yes / No			
Are you limited in the areas you feel comfortable to chew with?	Yes / No			
Do you have trouble with food getting caught in between teeth?	Yes / No	Where? _____		
Do you experience pain or fatigue of the chewing muscles or jaw joint?	Yes / No			
Do you clench or grind your teeth?	Yes / No	During the day? _____		At night? _____
Do you feel your breath may be affected by the health of your mouth?	Yes / No			
Are your gums tender or do they bleed when you brush?	Yes / No	When you floss? _____		
How frequently do you use dental floss? _____				
Do you wish to maintain your own teeth and avoid dentures?	Yes / No			
Have you been told your teeth need to be cleaned more frequently than twice a year?	Yes / No			
Does dental treatment make you feel nervous?	Yes / No	Slightly	Moderately	Extremely
Have you had any previous bad experiences at the dentist?	Yes / No	_____		
Have you ever had Nitrous Oxide (laughing gas) to help you relax?	Yes / No			
Do you have any other concerns you would like us to know about or which you feel might affect your care in our office?	Yes / No	_____		

Appointments and Consent

A charge will be made for a failed or cancelled appointment without prior notification of at least 48 business hours. Once an appointment is made, please remember this time has been reserved for you. A broken appointment is a loss to everyone. I authorize and give consent to perform dental services agreed between doctor and patient and/or patient or guardian to be necessary or advisable in the diagnosis and treatment of this patient, including local anesthesia and medication as indicated. To the best of my knowledge, I have answered every question completely and accurately.

Patient, Parent or Guardian Signature: _____ **Date:** _____

Medical History Update

To the best of my knowledge, I have answered every question completely and accurately. If I ever have any change in my health, or if my medications change, I understand it is my responsibility to inform the dentist at my next next appointment.

Update 1 - Patient/Guardian Signature: _____ **Date:** _____ **Dentist or Hygienist:** _____

Update 2 - Patient/Guardian Signature: _____ **Date:** _____ **Dentist or Hygienist:** _____

Update 3 - Patient/Guardian Signature: _____ **Date:** _____ **Dentist or Hygienist:** _____

Update 4 - Patient/Guardian Signature: _____ **Date:** _____ **Dentist or Hygienist:** _____

I acknowledge receipt of the
Notice of Privacy Policy &
Dental Materials Fact Sheet

X _____