DENTAL HISTORY

Date of your last visit to a dentist:_____

Reason for your last visit (or series of visits)_____

Do you have any of your x-rays or dental records?_____

In respect to any previous dental treatment have you:

Ever fainted?_____

Had an allergic reaction?_____

Had abnormal bleeding?_____

Any other complications during or following dental treatment?_____

Describe:_____

Do your gums bleed on brushing or eating?_____

Does food catch between your teeth?_____

Have your teeth drifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose?_____

_____

Are any of your teeth sensitive to heat, cold, or pressure?_____

Do you grind your teeth or clench your jaws?_____

Do you have pain or clicking in the jaw joint around your ear?_____

Have your jaw muscles ever been sore?_____ If yes, describe:_____

_____

Are there sores or growths in your mouth?_____

Do any of your teeth ache?_____

Do you have any other dental complaint?_____

NOTE: A change in your health status is to be reported to our office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been answered accurately.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third-party payors and/or other health practitioners.

Signature:_____ Date:_____

Witness:_____ Date:_____