

## 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: \_\_\_\_\_