Dental History

1. Name of previous dentist: _____ 2. When were you last seen? _____

3. What prompted you to seek dental care at this time? _____

4. Have you had bad dental experiences in the past? □ Yes □ No

5. Are you apprehensive about future dental treatment? □ Yes □ No

6. Have you had any periodontal (gum) treatment? □ Yes □ No

7. Do your gums bleed or feel tender? □ Yes □ No

8. Are your teeth sensitive to any of the following? (Please circle all that apply) *Hot / Cold / Sweet / Pressure*

9. Are you unhappy with the appearance of your teeth? □ Yes □ No

10. Are you aware of grinding or clenching your teeth? □ Yes □ No

11. Do you have any of the following? (Please circle all that apply) *Headaches / Earaches / Neck pains*

12. How do you clean your teeth? Please circle the appropriate answer:

Brushing- How Often? *1 / 2 / 3 times per day / week / month*

Flossing- How Often? *1 / 2 / 3 times per day / week / month*

What tooth brush texture do you use? *Soft / Medium / Hard*

13. Do you use any of the following to clean your teeth?

□ Toothpicks □ Salt □ Baking Soda □ Mouth Rinses

□ Waterpik □ Peroxide □ Other: _____

14. Please rank (from 1 being most important to 4 being least important) the following in the order in which they would keep you from having treatment:

Fear of pain: ____ Lack of concern: ____ Cost of Treatment: ____ Missing Work Time: ____

15. Is there any other medical or dental information you think we should know about? _____

_____

Authorization and Release:

By signing this page, I acknowledge that I have read and that I understand the above information to the best of my knowledge. The above questions have been answered as accurately as possible and I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and 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 care practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

Signature (Parent's if Minor)

_____ Date: _____