

DENTAL HISTORY

What is your chief complaint? _____

YES NO

_____ Are you having any discomfort at this time?
_____ How long since your last dental visit? _____
_____ What was done then? _____
_____ How often did you visit a dentist before then? _____
_____ Have you lost any teeth? Why? _____
_____ Have they been replaced by: Fixed Bridge _____, Denture _____?
_____ Any complications with extractions? _____
_____ Are your teeth sensitive to: Heat _____, Cold _____, Sweets _____?
_____ Does food wedge between your teeth? Where? _____
_____ Do you have bleeding gums? When? _____ Where? _____
_____ Do you grind or clench your teeth? When? _____
_____ Do you get frequent headaches?
_____ Do you have upper or lower back pain?
_____ Do you have neck pain?
_____ Have you had your teeth straightened? When? _____
_____ Have you ever had gum treatment? When? _____
_____ Any pain in or around your ears? _____
_____ Are you aware of any swelling or lump in your mouth? Where? _____
_____ How often do you brush your teeth? _____ When? _____
_____ Do you use dental floss? How often? _____
_____ How long do you use a toothbrush before replacing it? _____
_____ Do you have any fear of dental treatment? If yes, explain _____
_____ Have you had any serious trouble associated with any previous treatment? If yes, explain _____
_____ Is there anything you want to change about your smile? If yes, explain _____

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Today's Date _____

We would like to get to know you better. It is important that we know about your dental and medical history since many things have a direct bearing on your dental health. Information you give to us is strictly confidential and will not be released to anyone without your permission.

Please complete all sections.

Name _____ Age _____ Date of Birth _____
Nickname _____ Social Security Number _____
Mailing Address _____ City _____ Phone _____
Street Address _____ City _____
Occupation _____ E-mail Address _____ Cell Phone _____
Business Name & Address _____ Business Phone _____
Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Name of Spouse _____ Occupation _____
Business Name & Address _____ Business Phone _____
Name of Previous Dentist _____ Emergency Contact _____
Address _____ City _____ Phone _____
Name of Physician _____ City _____ Phone _____
Patient Referred By _____ Person Who Will Pay for this Account _____
Name of Dental Insurance Company(s) _____ Policy # _____
Address _____ Ins. Co. Phone Number _____
Insured's SS # _____ Insured's Birth Date _____ Insured's Name _____

In the event that my account becomes delinquent for more than 60 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all collection costs, court costs, attorney fees, and interest fees accrued with the collection of this account.

Patient Signature _____