DENTAL HISTORY

Patient Name:____Birth Date:____________________

General Physician Name:___________________________________Phone:_________________________

Why have you come to the dentist today?____

Are you currently in pain?		Yes	No
Do you require antibiotics before dental treatment?		Yes	No
Your current dental health is:	**Good**	**Fair**	**Poor**
Have you ever had a serious/difficult problem associated with any previous dental work?		Yes	No
Do you have any allergies?____		Yes	No
Do you floss daily?		Yes	No
Do you brush daily**?**		Yes	No
Have you ever had gum treatment?		Yes	No
Do your gums ever bleed?		Yes	No
Do your gums ever itch?		Yes	No
Have you ever had periodontal disease?		Yes	No
Do you now or have you ever experienced pain/ Or discomfort in your jaw joint (TMJ/TMD)?		Yes	No
Are your teeth sensitive to heat, cold or anything else?		Yes	No
Do you have any loose teeth?		Yes	No
Do you still have wisdom teeth?		Yes	No
Would you like fresher breath?		Yes	No
Would you like whiter teeth?		Yes	No
Are you happy with the way your smile looks?		Yes	No

If not, what would you change?____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I authorize the dental staff to perform any necessary dental services I may need during diagnosis and treatment, with my informed consent.

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Signature Date