## Patient Dental History

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ○ | ○ | 1. Do your gums bleed while brushing or flossing? | ○ | ○ | 8. Do you have frequent headaches? |
| ○ | ○ | 2. Are your teeth sensitive to hot or cold liquids/foods? | ○ | ○ | 9. Do you clench or grind your teeth? |
| ○ | ○ | 3. Are your teeth sensitive to sweet or sour liquids/foods? | ○ | ○ | 10. Do you bite your lips or cheeks frequently? |
| ○ | ○ | 4. Do you feel pain in any of your teeth? | ○ | ○ | 11. Have you ever had any difficult extractions in the past? |
| ○ | ○ | 5. Do you have any sores or lumps in or near your mouth? | ○ | ○ | 12. Have you ever had prolonged bleeding following extractions? |
| ○ | ○ | 6. Have you had any head, neck or jaw injuries? | ○ | ○ | 13. Have you ever experienced difficulty becoming completely anesthetized in the dental office? |
| ○ | ○ | 7. Have you ever experienced any of the following problems with your jaw: | ○ | ○ | 14. Have you had any orthodontic work? |
| ○ | ○ | a) Clicking? | ○ | ○ | 15. Have you ever had instruction on the correct method of brushing and flossing your teeth? |
| ○ | ○ | b) Pain? | | | |
| ○ | ○ | c) Difficulty in Opening or Closing? | | | |
| ○ | ○ | d) Difficulty in Chewing? | | | |

Someone not living with you to notify in case of emergency: _____
*Last* *First* *Phone Number*

Whom may we thank for referring you to our office? _____
*Last* *First*

## Patient Release

SIGNATURE: _____
*Patient, Parent or Guardian* *Date*

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

## Dentist's Comments

_____
_____
_____
_____
_____
_____
_____
_____
_____
*Signature of Dentist* *Date*