PATIENT DENTAL HISTORY

Name of previous Dentist and Location______________________________

Date of Last Exam____________________

Question	Yes	No
1.) Do your gums bleed while brushing or flossing?		
2.) Are your teeth sensitive to hot or cold liquids/foods?		
3.) Are your teeth sensitive to sweet/sour liquids/foods?		
4.) Do you feel pain to any of your teeth?		
5.) Do you have any sores or lumps in or near your mouth?		
6.) Have you had any head, neck or jaw injuries?		
7.) Have you ever experienced any of the following problems in your jaw?		
Clicking		
Pain (joint, ear, side of face)		
Difficulty in opening or closing		
Difficulty in chewing		
8.) Do you have frequent headaches?		
9.) Do you clench or grind your teeth?		
10.) Do you bite your lips or cheeks frequently?		
11.) Have you had any difficult extractions in the past?		
12.) Have you ever had prolonged bleeding following any extractions?		
13.) Have you ever had any orthodontic treatment?		
14.) Do you wear dentures or partial?		
15.) Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
16.) Do you like your smile?		

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my. I authorize the dentist to release any information including the diagnosis and the records of any treamtment or examination rendered to me or my child during the period of such Dental care to third party payors and/or helath practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is pre-payment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or future account balances.

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Signature of patient or parent/guardian Date