Bellbrook *Neighborhood Dental*

PATIENT'S DENTAL HISTORY

Patient's Name _____ Date of Birth _____

Reason for this visit _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (Name and location) _____

Have you had a complete series of dental films (X-rays) taken? When/where? _____

How often do you brush your teeth? _____ How often do you floss you teeth? _____

Is your drinking water fluoridated? _____

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Are your teeth sensitive to hot or cold Liquids / foods?	☐	☐	Have you noticed any loosening of your teeth?	☐	☐
Do you feel pain to any of your teeth?	☐	☐	Does food tend to get caught between your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	Have you ever had periodontal treatment (gums)?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐	Ever worn a bite plate or other appliance?	☐	☐
Have you ever experienced any of the following problems in your jaw?			Have you ever had any difficult extractions?	☐	☐
Clicking	☐	☐	Have you ever had any prolonged bleeding following extractions?	☐	☐
Pain (Joint, Ear, Side of face)	☐	☐	Do you wear dentures or partials?	☐	☐
Difficulty in opening or closing	☐	☐	If Yes, date of placement _____		
Difficulty in chewing	☐	☐	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you have frequent headaches?	☐	☐	Do you clench or grind your teeth?	☐	☐

If you could change ANYTHING about your smile, what would you change? _____

_____

_____

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 health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. 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 dependents.

X_____ Date _____

Signature of patient or parent / guardian if minor

Doctor's Comments _____

_____

_____

Signature _____ Date _____

DENTAL HISTORY

New: 9-12-11