DENTAL HISTORY

Last Name _____ First Name_____

Address _____

City _____ State _____ Zip _____

1. Date of last dental visit? _____/_____/_____ Date of last dental x-rays? _____/_____/_____

2. Reason for last dental visit?

_____

3. When was your last dental cleaning? _____

4. Do you have any concerns or ever experienced in problems with previous dental care during dental visit?

_____

_____

5. Do your gums bleed? (**circle**) Yes No 6. Are you happy with your smile? (**circle**) Yes No

7. Are your teeth loose? (**circle**) Yes No 8. Have you ever had periodontal surgery? (**circle**) Yes No

9. Have you ever been told you have gum disease? (**circle**) Yes No

10. Have you ever been told you have bad breath? (**circle**) Yes No

11. Are your teeth sensitive to? (**circle all that apply**) Sweets Cold Heat Pressure

12. Have your ever had any pain in your jaw joints (clicking, popping)? (**circle**) Yes No

If no, please explain:

_____

13. What would you change about the present condition of your mouth?

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature_____ **Date** _____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print_____ Relationship_____

Signature _____ Date _____

Health History Update: On a regular basis we will be asking about any changes in your medical history.

Date	Changes/Comments	Signature of Patient and Dentist
____/_____/_____	_____	_____