

DENTAL HISTORY - DR.'S SUMMARY

Home Care _____ Dental IQ I II III IV V

Primary Complaint _____

DENTAL HISTORY

Date of last dental visit _____ Reason _____

IN RESPECT TO ANY PREVIOUS DENTAL TREATMENT HAVE YOU:

Ever fainted? _____

Had an allergic reaction? _____

Had abnormal bleeding? _____

Any other complications during or following dental treatment? _____ If yes, Describe. _____

Do you have any dental needs, discomforts or requests at this time? _____

Do your gums bleed on brushing or eating? _____

Does food catch between your teeth? _____

Have your teeth shifted, are there spaces between your teeth now where there was none before, are your teeth flaring, or are some of your teeth becoming loose? _____

Are any of your teeth sensitive to heat, cold, pressure? _____

Do you have pain or clicking in the jaw joint around your ear? _____

Have your jaws ever been sore? _____ If yes, Describe. _____

Do any of your teeth ache? _____

Have you ever had: periodontal (gum) treatment or surgery? _____

oral surgery (teeth removed)? _____

orthodontic treatment? _____

your teeth ground or bite adjusted? _____

worn a bite plate or other appliance? _____

Are you dissatisfied with: the appearance of your teeth? _____

the shape of your teeth? _____

the shade of your teeth? _____

the alignment of your teeth? _____

the bite (occlusion) of your teeth? _____

old fillings or dental work (are there any fillings etc., that you don't like looking at?) _____

other? _____

Habits: Do you: hold foreign objects with your teeth such as pencils, pipe, pins, fingernails? _____

mouth breathe while awake or asleep? _____

bite your lips or cheeks regularly? _____

grind your teeth or have you been told you do? _____

Are you anxious, or do you feel nervous about dental treatment? _____

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST TIME POSSIBLE

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission to release Health information. I grant the right to the dentist to release health information obtained from me and information about my dental treatment to third party payers and/or health practitioners.

Person completing form (signature) _____

Person completing form (print name) _____

If other than patient, indicate relation _____ Date: _____