DENTAL HISTORY

1.) Reason for today's visit: Check up _____ Cleaning _____ Toothache _____

Chief Complaint: _____

2.) When was your last visit to the dentist: _____

What treatment was performed: _____

Dentists Name: _____ Phone: _____

3.) When was your last full set of x-rays taken: _____

Were they requested: Yes _____ No _____

4.) Have you ever had prolonged bleeding after an extraction: Yes _____ No _____

5.) Have you had any problems with dental treatment: Yes _____ No _____

6.) Do you have any problems associated with movement of the

lower jaw such as: clicking, popping, pain or locking when open: Yes _____ No _____

7.) What is important to you in a dentist or dental practice: _____

_____

8.) Do your gums bleed easily? Yes _____ No _____

9.) Do you feel you have bad breath? Yes _____ No _____

10.) Are you teeth sensitive to hot and cold? Yes _____ No _____

11.) Would you like your teeth whiter? Yes _____ No _____

12.) Are there any cosmetic changes you would like to have done? Yes _____ No _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and or medication. I further certify that I consent to the performance of x-rays and oral examination.

_____ _____

Signature of patient/guardian Date