The DENTAL TEAM
"WE CATER TO COWARDS"

Date _____

New Patient Dental History

How can we help you? _____

When was your last dental visit? _____ Were X-Rays taken? ❑ Yes ❑ No Date _____

Was there any dental treatment recommended that has not been completed? ❑ Yes ❑ No

If yes, please explain _____

How often did you visit the Dentist in the past? _____

Previous Dentist name, address, telephone number _____

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

Are you in any dental discomfort now? _____

Have you had any prior dental experiences that have been unpleasant? ❑ Yes ❑ No

If yes, please explain _____

Do your gums bleed while brushing or flossing? ❑ Yes ❑ No	Do you have frequent headaches? ❑ Yes ❑ No
Are your teeth sensitive to hot or cold liquids/foods or sweets? ❑ Yes ❑ No	Are you having any problems with snoring? ❑ Yes ❑ No
Are you aware of any sores or lumps in or near your mouth? ❑ Yes ❑ No	Have you ever had periodontal treatment (gums)? ❑ Yes ❑ No
Do you feel pain in your teeth? ❑ Yes ❑ No	Have any of your teeth become loose? ❑ Yes ❑ No
Have you had any head, neck or jaw injuries? ❑ Yes ❑ No	Does food tend to become caught between your teeth? ❑ Yes ❑ No
Do you clench or grind your teeth? ❑ Yes ❑ No	Have you had orthodontic treatment/braces? ❑ Yes ❑ No
Have you ever experienced any of the following problems in you jaw? ❑ Clicking or popping while chewing? ❑ Pain (Joint, ear or side of face)? ❑ Difficulty in chewing? ❑ Difficulty in opening or closing? ❑ Avoid eating on one side?	Have you ever had prolonged bleeding ❑ Yes ❑ No Do you wear dentures or partials? ❑ Yes ❑ No If yes, date of placement _____ Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ❑ Yes ❑ No Do you like your smile? ❑ Yes ❑ No

If you could change anything about your SMILE, what would that be? _____

Would you like to whiten/bleach your teeth? ❑ Yes ❑ No

Authorization and Release

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND 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 IF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS 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 OD ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. THERE WILL BE A FINANCE CHARGE ON ALL BILLS MORE THAN 60 DAYS OLD.

_____ _____

Patient or Authorized Guardian Signature Date

DOCTOR'S COMMENTS _____

_____

_____ _____

Doctor Signature Date