Dental Information

Patient: Submitted: 11/7/2024

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws.

PATIENT INFORMATION

Patient Name:

Date of Birth:

DENTAL INFORMATION

DENTAL HEALTH

PLEASE SELECT YES OR NO TO THE FOLLOWING DENTAL HEALTH QUESTIONS:

Do you have any immediate dental concerns?	Yes [ ] No [ ]	Are you currently experiencing dental pain or discomfort?	Yes [ ] No [ ]
Have you had any problems with previous dental treatment?	Yes [ ] No [ ]	Have you ever had a serious injury to your head or mouth?	Yes [ ] No [ ]
Do your gums bleed when you brush or floss?	Yes [ ] No [ ]		
Have you ever had teeth become loose, without injury?	Yes [ ] No [ ]	Have you had any periodontal (gum) treatments?	Yes [ ] No [ ]
Have you had any cavities in the last 3 years?	Yes [ ] No [ ]	Are your teeth sensitive to cold, hot, sweets or pressure?	Yes [ ] No [ ]
Do you ever have times your mouth feels dry?	Yes [ ] No [ ]	Do you brux, grind, or clinch your teeth?	Yes [ ] No [ ]
Do you have earaches or neck pains?	Yes [ ] No [ ]		
Do you have any clicking, popping or discomfort in the jaw?	Yes [ ] No [ ]	Have your teeth become shorter, thinner, or worn in the last 5 years?	Yes [ ] No [ ]
Have you ever had a sleep test?	Yes [ ] No [ ]		
Have you ever had orthodontic (braces) treatment?	Yes [ ] No [ ]	Do you have sores or ulcers in your mouth?	Yes [ ] No [ ]
Do you wear dentures or partials?	Yes [ ] No [ ]	Is there anything you would like to change about your smile?	Yes [ ] No [ ]

DENTAL HISTORY

Complete the following fields if you are NEW PATIENT or if you have regular appointments with another dental provider.

Dental Information

Patient: Submitted: 11/7/2024

Date of your last dental exam
Date of your last dental x-rays?

PREVIOUS OR OTHER DENTAL PROVIDER INFORMATION

Dental Provider or
Practice Name:

Dental Provider or
Practice Phone Number:

SIGNATURE

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.