Patient Dental History

Patient name: ___________________________________ *date:* ____/____/_____

Previous dentist: _____________________________________ *City* ________________ *State* _____ *Phone* ____-____-_____

Date of your last dental visit: _____/_____/_____ *Date of last dental x-rays:* ____/____/_____

	Yes	No
1. *Do your gums bleed during or after brushing/flossing?*	☐	☐
2. *Are your teeth sensitive to hot or cold liquids/foods?*	☐	☐
3. *Are your teeth sensitive to sweet or sour liquids/foods?*	☐	☐
4. *Do you feel pain to any of your teeth?*	☐	☐
5. *Do you have an sores or lumps on or near your mouth?*	☐	☐
6. *Have you had an head, neck or jaw injuries?*	☐	☐
7. *Have you ever experienced any of the following problems in your jaw:*		
a. *Clicking…………………………………………………………………..*	☐	☐
b. *Pain (jaw joint, ear, side of face)…………………………….*	☐	☐
c. *Difficulty in opening or closing your mouth…………….*	☐	☐
d. *Difficulty in chewing……………………………………………..*	☐	☐
8. *Do you have frequent headaches?..*	☐	☐
9. *Do you clench or grind your teeth?.......................................*	☐	☐
10. *Do you bite your lips or cheeks frequently?...........................*	☐	☐
11. *Have you ever had any difficult extractions in the past?.........*	☐	☐
12. *Have you ever had any prolonged bleeding following extractions?...*	☐	☐
13. *Have you had any orthodontic treatment, braces, Invisalign or any other corrective device?.........*	☐	☐
14. *Do you wear dentures or partials?..*	☐	☐
15. *Have you ever received oral hygiene instructions regarding the care of our teeth and gums?.................*	☐	☐
16. *Do you like your smile?..*	☐	☐

If no, what would you change? ____

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Authorization and Release

I certify that I have read and understand the above information 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 Eastview Family Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors 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 service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____ *date:* ____________________

Signature of patient (or parent/guardian – if under 19)