

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_  
Date of Last Exam \_\_\_\_\_

*In an effort to serve you best, please fill out the following so that we can custom tailor your future dental treatment to your specific needs.*

1. How have your relationships been with dental offices in the past? Good Satisfactory Poor
2. Do dental procedures make you nervous? Yes No  
If yes, anything specific? \_\_\_\_\_
3. Do you have any specific preferences during your dental visits? Yes No  
If yes, PLEASE LIST:
  
4. How frequently were you being seen for checkups/cleanings in the past? Every 6 months  
Every 3-4 months  
Once per year  
Never regularly
  
5. Have you ever had a problem with gum disease? ..... Yes No
6. Have you ever been referred to or treated by a Periodontist (Gum Specialist)? Yes No
7. Are you interested in options to straighten your teeth? ..... Yes No
8. Do you wear dentures or partials?..... Yes No  
If yes, do they fit well / are they comfortable? Yes No
  
9. Are you missing any teeth that you would like to have replaced? ..... Yes No
10. Are you interested in WHITENING your teeth? ..... Yes No
11. Do you clench or grind your teeth? ..... Yes No
12. Do you wear any kind of dental appliances at night (night-guard, retainer)?.. Yes No
13. Have you had any problems with your jaw joints (TMJ) in the past? ..... Yes No
14. Do you have any problems with tooth sensitivity? ..... Yes No
  
15. Are you having any specific dental problems currently? Yes No  
If yes, please describe:

## 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 dentist 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 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 of all services rendered on my behalf or my dependents' behalf.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient (or Parent if minor)