

DENTAL HISTORY

(Please place a "X" to indicate if you had any of the following.)

		Y	N			Y	N
Reason for today's visit:	Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Former Dentist:	Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth pain, brushing	<input type="checkbox"/>	<input type="checkbox"/>	
City, State:	Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment (Braces)	<input type="checkbox"/>	<input type="checkbox"/>	
Date of last visit:	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Pain around ear	<input type="checkbox"/>	<input type="checkbox"/>	
Date of last x-rays:	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment (Gums)	<input type="checkbox"/>	<input type="checkbox"/>	
How often do you brush?	Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to cold	<input type="checkbox"/>	<input type="checkbox"/>	
How often do you floss?	Clicking or popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to hot	<input type="checkbox"/>	<input type="checkbox"/>	
Who may we thank for referring you:	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>	
Additional comments:	Fingernail biting	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to biting	<input type="checkbox"/>	<input type="checkbox"/>	
	Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sores or growths in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	
	Foreign objects	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	
	Gums swollen or tender	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	
	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date