ADULT DENTAL HISTORY

Patient Name:	D.O.B.	M	D	Y	Patient/Parent/Guardian Initial:	Date:	M	D	Y

GENERAL CONSENT FOR TREATMENT: I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my child's/my medical and dental histories. Should there be any change to either my child's/my health status or any other information I have provided, I will advise this dental office. I understand that information provided from or to my child's/my medical doctor or another health care provider may be necessary. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment.

X _____ _____ _____

Signature of Patient/Parent/Guardian (circle one) Print Name of Patient/Parent/Guardian Date

_____ _____

Signature of Treating Dentist Date

ADULT DENTAL HISTORY (Age 16 and older): Please circle YES or NO to each question. If unsure, please consult the dentist.

1. Are you in pain? _____ YES/NO Are there any growths or sore spots in your mouth? _____ YES/NO

2. Is there a dental problem you would like treated as soon as possible? _____ YES/NO

3. Are any of your teeth sensitive to heat, cold, sweets or pressure (please circle) _____ YES/NO

4. When was your last dental visit? _____ Last professional cleaning? _____ Last dental x-rays? _____

5. Have you been seeing a dentist regularly? YES/NO How Often? _____

6. Have you ever been advised to take antibiotics before routine dental work such as cleanings or removal of teeth? YES/NO

7. Have you ever had any of the following treatments?
   - Periodontal treatment (treatment of the gums) _____ YES/NO
   - Orthodontic Treatment (braces, retainers, appliances to straighten teeth) _____ YES/NO
   - A biteguard/nightguard (to treat grinding or clenching habits) _____ YES/NO
   - Your bite adjusted or teeth ground (not including fillings) _____ YES/NO
   - Oral surgery (wisdom teeth/jaw joints/broken jaw/dental implants) _____ YES/NO

8. Do your gums bleed when you brush or eat? YES/NO/SOMETIMES Do you have pain or swelling of your gums? YES/NO

9. Do any of your teeth feel loose?_____YES/NO Do you feel like your teeth have shifted? _____ YES/NO

10. Does food catch between your teeth? _____ YES/NO

11. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____ YES/NO

12. Do you use dental floss/proxabrush/stimudents to clean between your teeth? YES/NO How often? _____

13. Have you ever experienced any of the following jaw problems?
   - Popping/clicking in your jaw joints? _____ YES/NO Right/Left/Both
   - Pain in your jaw joints, around your ear, or side of your face? _____ YES/NO Right/Left/Both
   - Difficulty/pain in opening or closing? _____ YES/NO Right/Left/Both
   - Pain in the joints when chewing? _____ YES/NO Right/Left/Both
   - Jaw locking open or closed? _____ YES/NO

14. Do you: Clench or grind your teeth while awake or sleeping? YES/NO Chew on your cheeks or lips? YES/NO
   Put objects in your mouth (pens/fingernails/pins/nails)? YES/NO Mouth breathe (awake/asleep)? YES/NO

15. Does having dental treatment make you feel nervous or uncomfortable? _____ YES/NO

16. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment? YES/NO
   _____

17. Are you unhappy with the appearance of your teeth? YES/NO What would you like to see changed? _____
   _____

18. Is it important for you to keep your natural teeth? _____ YES/NO

19. Do you feel your dental health affects your overall health? _____ YES/NO

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