**PATIENT DENTAL HISTORY**

REASON FOR THIS VISIT D

WHEN WAS YOUR LAST DENTAL HYGIENE VISIT D

HOW OFTEN DO YOU BRUSH YOUR TEETH HOW OFTEN DO YOU FLOSS YOUR TEETH D

DO YOU USE A TOOTHPASTE OR MOUTH RINSE WITH FLUORIDE D

WHAT IS YOUR MAIN SOURCE OF DRINKING WATER CITY WELL BOTTLED FILTERED

**D YES NO YES NO**

1. DO YOUR GUMS BLEED WHILE BRUSHING

OR FLOSSING………………………………………..

1. ARE YOUR TEETH SENSITIVE TO HOT OR

COLD LIQUIDS/FOODS…………………………….

1. ARE YOUR TEETH SENSITIVE TO SWEET

OR SOUR LIQUIDS/FOODS………………………...

1. DO YOU FEEL PAIN TO ANY OF YOUR TEETH...
2. DO YOU HAVE ANY SORES OR LUMPS IN

OR NEAR YOUR MOUTH…………………………..

1. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES……………………………………………..
2. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW:

CLICKING……………………………………….

PAIN (JOINT, EAR, SIDE OF FACE)…………..

DIFFICULTY IN OPENING OR CLOSING……

DIFFICULTY IN CHEWING……………………

1. DO YOU HAVE FREQUENT HEADACHES……….

DOCTOR’S COMMENTS D

D

D

**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 acknowledge I have been provided with and have reviewed a copy of First City Dental’s privacy, security, and breach notification policies and procedures. I understand that I should ask the privacy officer if I have any questions about these policies and procedures. 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.

**X** D DATE D

Patient Signature or Parent/Guardian if a minor

Hygienist Initials Date Doctor Initials Date d

**REGISTRATION / HEALTH HISTORY**

1. DO YOU CLENCH OR GRIND YOUR TEETH…...
2. DO YOU BITE YOUR LIPS OR CHEEKS

FREQUENTLY………………………………………...

1. HAVE YOU NOTICED ANY LOOSENING OF

YOUR TEETH……………………………………….

1. DOES FOOD TEND TO BECOME CAUGHT

BETWEEN YOUR TEETH………………………….

1. HAVE YOU EVER HAD PERIODONTAL (GUMS) TREATMENT………………………………………..
2. HAVE YOU EVER WORN A SPLINT OR

NIGHT GUARD……………………………………...

1. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST, INCLUDING PROLONGED BLEEDING………………………….
2. DO YOU WEAR DENTURES OR PARTIALS…….

IF YES, DATE OF PLACEMENT D

1. DO YOU HAVE PROBLEMS WITH NERVOUSNESS

OR ANXIETY WITH DENTAL APPOINTMENTS…