

ADULT DENTAL HISTORY

Patient Name: _____	D.O.B.	M	D	Y	Patient/Parent/Guardian Initial: _____	Date:	M	D	Y
<p>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.</p>									
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

ADULT DENTAL HISTORY