

Patient Dental History

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| 1. Do your gums bleed while brushing or flossing? | Yes | No |
| 2. In general, are your teeth sensitive to hot or cold? | Yes | No |
| 3. In general, are your teeth sensitive to sweet or sour? | Yes | No |
| 4. In general do you feel pain to any of your teeth? | Yes | No |
| 5. Do you have any sores or lumps in or near your mouth? | Yes | No |
| 6. Have you ever experienced any of the following problems with your jaw? | | |
| Clicking | Yes | No |
| Pain (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing | Yes | No |
| Difficulty in chewing | Yes | No |
| 7. Do you grind or clench your teeth? | Yes | No |
| 8. Do you bite your lips or cheeks frequently? | Yes | No |
| 9. Have you ever had any difficult extractions? | Yes | No |
| 10. Have you ever had any prolonged bleeding following an extraction? | Yes | No |
| 11. Have you had any orthodontic (braces) treatment? | Yes | No |
| 12. When did you last have your teeth cleaned? _____ | | |
| 13. As time goes by, our teeth tend to get darker. Would you be interested in restoring them to their original whiteness? | Yes | No |
| 14. What would you change about your smile? _____ | | |
| 15. If you had a perfect smile, what would it look like? _____ | | |
| 16. Have you ever been told you need to take antibiotics prior to receiving treatment? | Yes | No |
| 17. If yes, antibiotic _____ preferred pharmacy _____ | | |

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions and questions on the reverse side 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 healthcare practitioners (this applies to those with dental insurance except for Blue Dental and Wellmark BC/BS since we are not participating providers for these insurance companies). I authorize and request my insurance company to pay dental benefits directly to the dentist, or dental group (this applies to those with dental insurance except for Blue Dental and Wellmark BC/BS of Iowa.) I understand that my dental insurance carrier may pay less than the actual charge for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependants.

_____ Date _____
Signature of patient (parent/guardian if minor)

Doctor's comments _____

Doctor's signature _____ Date _____