SHADED AREAS - OFFICE USE ONLY

MEDICAL ALERT	CONDITION	PRE MEDICATION	ALLERGIES	ANAEST

PATIENT NAME:	CHART NO:	DATE:

REASON FOR INITIAL VISIT:

LAST DENTAL VISIT: Date:

LAST DENTAL CLEANING: Date:

PREVIOUS DENTIST:

Please check YES or No (If not sure, check off NS)

	No	NS	Yes
Are you suffering from pain now?	◯	◯	◯
Are any of your teeth becoming loose?	◯	◯	◯
Have any of your teeth shifted?	◯	◯	◯
Does food get caught between your teeth?	◯	◯	◯
Are any teeth sensitive to: cold ☐ hot ☐ biting ☐ pressure ☐ sweet ☐ bitter ☐	◯	◯	◯
Is there any swelling or pain of your gums?	◯	◯	◯
Is there a history of gum disease in your family?	◯	◯	◯
Are you aware of sore/growths in your mouth?	◯	◯	◯
Do you notice any bleeding from your gums when you brush your teeth, or other?	◯	◯	◯
Have you had a local anaesthetic (freezing)?	◯	◯	◯
… any complications?	◯	◯	◯
Have you had any teeth extracted?	◯	◯	◯
… any complications?	◯	◯	◯
Do you have burning sensation of lips or tongue?	◯	◯	◯
Does your mouth tend to get dry?	◯	◯	◯
Do you have bad taste in your mouth or bad breath?	◯	◯	◯
Are you nervous about having dental treatment?	◯	◯	◯
Have you ever had an upsetting experience in dental office?	◯	◯	◯

EXPLAIN:

ORAL HYGIENE	No	NS	Yes
Do you use Dental aids?	◯	◯	◯
Do you use any fluoride/mouth rinses?	◯	◯	◯
Are you happy with appearance of your teeth?	◯	◯	◯
What would you like to change about your teeth?			
How often do you brush your teeth?			
How often do you floss your teeth?			

JAW PROBLEMS **Do you have any of the following:**	No	NS	Yes
Clicking/popping of jaw when opening/closing?	◯	◯	◯
Pain (in jaw joints- ear, side of face)?	◯	◯	◯
Difficulty in opening or closing your mouth?	◯	◯	◯
Pain and/or difficulty in chewing?	◯	◯	◯
Pain when cleaning your teeth?	◯	◯	◯
Have you ever had implant surgery in one or both of your jaw joints?	◯	◯	◯
If yes, who performed the surgery and when was it done?			
Are you being followed-up by a dental specialist?	◯	◯	◯

HABITS **Do you -**	No	NS	Yes
Clench or grind your teeth while asleep?	◯	◯	◯
Bite your lips or cheeks regularly?	◯	◯	◯
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?	◯	◯	◯
Breath through your mouth while awake or sleep?	◯	◯	◯

TREATMENTS **Please check off the following treatments you have had:**	No	NS	Yes
Orthodontic treatment (braces)?	◯	◯	◯
Oral Surgery?	◯	◯	◯
Periodontal treatment (gum surgery)?	◯	◯	◯
Teeth ground of bite adjusted?	◯	◯	◯
Worn bite plate or other appliance?	◯	◯	◯
Dental implants?	◯	◯	◯

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed by me, and I have had the chance to ask questions and to receive answers regarding any medical dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general or local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Patient ◯ Parent ◯ Guardian ◯ Date: Signature: