

SHADED AREAS - OFFICE USE ONLY

MEDICAL ALERT	CONDITION	PRE MEDICATION	ALLERGIES	ANAEST
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PATIENT NAME:	CHART NO:	DATE:
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REASON FOR INITIAL VISIT:

LAST DENTAL VISIT: Date: (mm/dd/yyyy)	LAST DENTAL CLEANING: Date: (mm/dd/yyyy)	PREVIOUS DENTIST:
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Please check YES or No (If not sure, check off NS)

	No	NS	Yes		No	NS	Yes
Are you suffering from pain now?				ORAL HYGIENE			
Are any of your teeth becoming loose?				Do you use Dental aids?			
Have any of your teeth shifted?				Do you use any fluoride/mouth rinses?			
Does food get caught between your teeth?				Are you happy with appearance of your teeth?			
Are any teeth sensitive to: cold <input type="checkbox"/> hot <input type="checkbox"/> biting <input type="checkbox"/> pressure <input type="checkbox"/> sweet <input type="checkbox"/> bitter <input type="checkbox"/>				What would you like to change about your teeth?			
Is there any swelling or pain of your gums?				How often do you brush your teeth?			
Is there a history of gum disease in your family?				How often do you floss your teeth?			
Are you aware of sore/growths in your mouth?				JAW PROBLEMS			
Do you notice any bleeding from your gums when you brush your teeth, or other?				Do you have any of the following:	No	NS	Yes
Have you had a local anaesthetic (freezing)?				Clicking/popping of jaw when opening/closing?			
... any complications?				Pain (in jaw joints- ear, side of face)?			
Have you had any teeth extracted?				Difficulty in opening or closing your mouth?			
... any complications?				Pain and/or difficulty in chewing?			
Do you have burning sensation of lips or tongue?				Pain when cleaning your teeth?			
Does your mouth tend to get dry?				Have you ever had implant surgery in one or both of your jaw joints?			
Do you have bad taste in your mouth or bad breath?				If yes, who performed the surgery and when was it done?			
Are you nervous about having dental treatment?							
Have you ever had an upsetting experience in dental office?				Are you being followed-up by a dental specialist?			

EXPLAIN:

HABITS	Do you -	No	NS	Yes	TREATMENTS	Please check off the following treatments you have had:	No	NS	Yes
Clench or grind your teeth while asleep?					Orthodontic treatment (braces)?				
Bite your lips or cheeks regularly?					Oral Surgery?				
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?					Periodontal treatment (gum surgery)?				
Breath through your mouth while awake or sleep?					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: (mm/dd/yyyy) Signature: