

# NORTH VAN DENTAL

## PATIENT DENTAL HISTORY

Reason for this visit: \_\_\_\_\_

When was your last dental visit: \_\_\_\_\_ What was done then: \_\_\_\_\_

Previous dentist (name and location): \_\_\_\_\_

Have you had a complete series of dental films (X-rays) taken at your previous dentist: \_\_\_\_\_

How often do you brush your teeth: \_\_\_\_\_ How often do you floss your teeth: \_\_\_\_\_

YES NO

YES NO

Do your gums bleed while brushing or flossing

Are your teeth sensitive to hot or cold liquids/foods

Are your teeth sensitive to hot or sour liquids/foods

Do you feel pain to any of your teeth

Do you have sores or lumps in or near your mouth

Have you had any head, neck or jaw injuries

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

Do you have frequent headaches

Do you clench or grind your teeth

Do you bite your lips or cheeks frequently

Have you noticed any loosening of your teeth

Does food tend to be caught between your teeth

Have you ever had periodontal treatment (gums)

Have you ever worn a bite plate or other appliance

Have you ever had any difficult extractions in the past

Have you ever had any prolonged bleeding following extractions

Do you wear dentures or partials

If yes, date of placement \_\_\_\_\_

Have you ever received oral hygiene instructions regarding the care of your teeth and gums

If you could change anything about your smile, what would you change?

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### 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 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 payors and/or health practitioner. 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 dependants.

\_\_\_\_\_  
Signature of patient or parent (if a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's comments

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date