# DENTAL HISTORY

Date of last visit to a Dentist?_____
Reason for your last visit or series of visits?_____
Do you have any of your x-rays or dental records?_____

WITH RESPECT TO ANY PREVIOUS DENTAL TREATMENT HAVE YOU:

23: Ever fainted?_____
24: Had an allergic reaction?_____
25: Had abnormal bleeding?_____
26: Any other complications during or following dental treatments? If yes, describe_____
27: Do your gums bleed on brushing or eating?_____
28: Does food catch between your teeth?_____
29. Have your teeth shifted, are there spaces between your teeth now where there were none? Are your teeth flaring or are some of your teeth becoming loose?_____
30: Are any of your teeth sensitive to heat, cold or pressure?_____
31: Do you grind your teeth or clench your jaws?_____
32: Do you have any pain or clicking in the jaw joint around your ear?_____
33: Are there any sores or growths in your mouth?_____
34: Do any of your teeth ache?_____
35: Do you have any other dental complaints?_____

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME.

WARNING: ANESTHETICS AND OTHER MEDICATIONS THAT MAY BE NECESSARY IN YOUR DENTAL TREATMENT MAY INTERACT WITH PRESCRIPTIONS, OVER THE COUNTER DRUGS, MEDICATIONS AND ILLICIT DRUGS. THESE INTERACTIONS MAY BE SERIOUS AND FATAL. YOU MUST INFORM THE DOCTOR OF ALL DRUGS AND MEDICATIONS YOU ARE NOW TAKING, OR HAVE EVER TAKEN. ALL INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND WILL NOT BE DISCLOSED WITHOUT YOUR PRIOR APPROVAL.

To the best of my knowledge, the foregoing questions have been answered accurately.
Permission to Release Health Information: I grant the right to the Dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form:
Signature_____
Print Name_____
If other than patient, indicate relationship:_____Date_____
Dentist's History Review and Significant Findings:_____

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Signature: Dr: