DENTAL HEALTH HISTORY

PATIENT NAME _____ **DATE OF BIRTH** _____

Reason for this visit _____

When was your last dental visit? _____ What services were performed? _____

How often did you visit the dentist before then? _____

General Dentist's Name: _____ Prior Dentist's Name (if less than 2 years) _____

Have you had a complete series of x-rays taken (when/where)? _____

How often do you brush your teeth? _____ How often do you floss? _____

Type of toothbrush used _____ Is your drinking water fluoridated? _____

	YES	NO		YES	NO
Do your gums bleed while brushing/flossing?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐	Have you noticed any loosening of your teeth?	☐	☐
Are your teeth sensitive to sweet or sour foods?	☐	☐	Does food get caught between your teeth?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you ever had periodontal treatment?	☐	☐
Do you have any sores in or near your mouth?	☐	☐	Ever worn a bite plate or other appliance?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐	Have you ever had any difficutly with extractions?	☐	☐
			Have you had prolonged bleeding with extractions?	☐	☐

Have you ever experienced any of the following problems in your jaw?

Clicking	☐	☐	Do you wear dentures or partials?	☐	☐
Pain (Joint, Ear, Side of Face, etc)	☐	☐	(If yes, date of placement) _____		
Difficuty in opening or closing	☐	☐			
Difficulty in Chewing	☐	☐	Have you ever received oral hygiene instruction		
Do you have frequent headaches?	☐	☐	regarding the proper care of your teeth and gums?	☐	☐
Do you clench/grind your teeth?	☐	☐			

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

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information, and that the above questions have been accurately answered. I understand that providing false or inaccurate information can be dangerous to my health. I authorize Dr. Steffer to release any information including my diagnosis and recored of any treatment treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to Dr. Steffer any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or that of my dependents.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____