PATIENT DENTAL HISTORY

ENG

PATIENT'S NAME _____ **DATE OF BIRTH** _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED 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 sweet or sour liquids/foods	☐	☐
Do any of your teeth feel painful	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you experienced any of the following problems		
Clicking in your jaw	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your jaw	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Have you ever worn a bite plate or other appliance	☐	☐
Have you had any difficult extractions in the past	☐	☐
**Have you ever had any prolonged bleeding following Extractions	☐	☐
**Do you wear dentures or partials	☐	☐
If yes, give the date they were placed _____		
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?

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 MY CHILD OR ME 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 GALLO DENTAL CARE, LLC OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE SOLE RESPONSIBLE FOR THE FINAL PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____ _____

PATIENT'S SIGNATURE / GUARDIAN OF MINOR **RELATIONSHIP WITH PATIENT** **DATE**

_____ _____

DENTIST'S SIGNATURE **DATE**

DENTIST'S COMMENTS: _____