

Name of Employer _____ Work Phone _____

Employer Address _____

Insurance Company _____ Group # _____

Ins. Co. Address _____

Patient Dental History

Please indicate which of the following applies to you. Check only if answer is yes.

- 1 Do your gums bleed while brushing or flossing? ____
- 2 Are your teeth sensitive to hot or cold liquids/foods? ____
- 3 Are your teeth sensitive to sweet or sour liquids/foods? ____
- 4 Do you feel pain to any of your teeth? ____
- 5 Do you have any sores or lumps in or near your mouth? ____
- 6 Have you had any head, neck or jaw injuries? ____
- 7 Have you ever experienced any of the following problems in your jaw:
 - a) Clicking? ____
 - b) Pain (joint, ear, side of face)? ____
 - c) Difficulty in opening or closing? ____
 - d) Difficulty in chewing? ____
- 8 Do you have frequent headaches? ____
- 9 Do you clench or grind your teeth? ____
- 10 Do you bite your lips or cheeks, frequently? ____
- 11 Have you had any difficult extractions in the past? ____
- 12 Have you had any orthodontic work? ____
- 13 Have you ever had any prolonged bleeding following extractions? ____
- 14 Have you ever had instruction on the correct method of brushing your teeth? ____
- 15 Have you ever had instructions on the care of your gums? ____

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.

Patient, Parent or Guardian

Date