Lakeshore **W**est **D**ental

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DENTAL HISTORY ***Please* ⊗ NO *or* YES *to each question. If unsure of a question, please consult with the dentist.***

Is there a dental problem you would like treated immediately? ……O NO O YES
Date of your last dental visit? _____ Last dental cleaning?_____ Last x-rays? _____

1. Have you been seeing a dentist regularly?…….. O NO O YES
2. Have you ever had any of the following? ……
   a. Periodontal Treatment (treatment of the gums)?…… O NO O YES
   b. Orthodontic Treatment(to straighten or realign teeth)?…….. O NO O YES
   c. A bit plate or any other appliance?…… O NO O YES
   d. Your bite adjusted or teeth ground?…….. O NO O YES
   e. Oral Surgery?(surgery in or about the mouth/jaw joint, or implant surgery in one or both of your …… jaw joints?) …… O NO O YES
   f. If you answered "yes to the last question, who performed the surgery_____ When?_____
   g. Are you being followed up by a dental specialist?……O NO O YES
3. Are there any growth or sore spots in your mouth?…….. O NO O YES
4. Do your gums bleed when brushing or eating, do you suffer from pain or swelling of your gums?.O NO O YES
5. Have you noticed any loose teeth, or, have any of your teeth shifted?…… O NO O YES
6. Does food catch between your teeth? ……O NO O YES
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? ……O NO O YES
8. Have you been advised to take antibiotics before a dental appointment?…… O NO O YES
9. Do you use dental floss, proxabrush or stimudents? How Often?_____ …… O NO O YES
10. How often do you brush your teeth? _____ Do you feel that you have bad breath?……. O NO O YES
11. Have you ever experienced any of the following jaw problems:
    a. Popping/clicking in your jaw joints? …… O NO O YES
    b. Pain in your jaw joints, around your ear, or side of your face? …… O NO O YES
    c. Difficulty in opening or closing?…… O NO O YES
    d. Pain when teeth are clenched? …… O NO O YES
    e. Pain or difficulty while chewing? …… O NO O YES
12. Do you have any of the following habits? …… O NO O YES
    a. Clenching or grinding your teeth while awake or asleep?…… O NO O YES
    b. Biting your cheeks or lips? ……O NO O YES
    c. Mouth breathing while awake or asleep?…….. O NO O YES
    d. Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? …… O NO O YES
13. Do you have any emotional concerns about having dental treatment? …… O NO O YES
14. Are you unhappy with the appearance of your teeth? …… O NO O YES
    and, what would you like to see changed_____
15. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns?…… O NO O YES

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical – dental history. ***Should there be any change in either my health status or any other information I have provided, I will advise this dental office.*** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____
Patient/parent guardian signature Print name

_____ _____
Reviewed by treating dentist Date