DENTAL HISTORY FORM

PREVIOUS DENTIST: ____

HAVE YOU EXPERIENCED ANY PAIN OR SORENESS IN THE MUSCLES OF YOUR FACE OR AROUND YOUR EAR? PLEASE EXPLAIN: ____

HOW LONG SINCE YOUR LAST DENTAL VISIT? ____

PURPOSE OF INITIAL VISIT? ____

ARE YOU AWARE OF ANY DENTAL PROBLEM? ____

HAVE YOU MADE REGULAR DENTAL VISITS? ____

WERE DENTAL X-RAYS RECENTLY TAKEN? ____

HAVE YOU LOST ANY TEETH? ______________________ WHY? ________________________________

WERE THERE ANY COMPLICATIONS AFTER TOOTH REMOVAL? __________________________________

DO YOU CLENCH OR GRIND YOUR TEETH? ____

DOES YOUR JAW CLICK OR POP? ____

DOES FOOD GET CAUGHT BETWEEN YOUR TEETH? ____

ARE YOUR TEETH SENSITIVE TO HOT? ______ COLD? ________ PRESSURE? _____ SWEETS?__________

HOW DO YOU FEEL ABOUT YOUR TEETH IN GENERAL? ____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ____________________________________

HAVE YOU HAD ANY UNPLEASANT DENTAL EXPERIENCES OR ANYTHING ABOUT DENTISTRY THAT YOU STRONGLY DISLIKE? ____

DO YOU HAVE ANY QUESTIONS OR CONCERNS? ____

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TERMS: PAYMENT FOR DENTAL WORK IS DUE IN FULL 30 DAYS FOLLOWING COMPLETION UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE WITH THIS OFFICE. A SERVICE CHARGE OF 1.5% ON THE UNPAID BALANCE (18% ANNUAL PERCENTAGE RATE) WILL BE CHARGED AFTER 30 DAYS.
I UNDERSTAND THAT CREDIT BUREAU REPORTS MAY BE OBTAINED IN CASE FINANCING MAY BE REQUESTED.

SIGNATURE: ____ DATE: _____________________