

DENTAL HISTORY

Date of Last Exam and X-Rays _____

Type of treatment: _____

Difficulties with past treatment : _____

Do you have:

Bleeding Gums _____ Pain around Ear _____
Clenching or Grinding of teeth _____ TMJ-Jaw Clicking _____
Swelling of lumps in mouth _____ Headaches _____
Frequent blisters on lips of mouth _____

Chief oral complaint: _____

What are you here for today? _____

SOCIAL HISTORY

Do you smoke? YES _____ NO _____ If yes, packs per day _____

Do you drink alcohol? YES _____ NO _____ EXPLAIN _____

Are you an I.V drug user YES _____ NO _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

DATE

SIGNATURE