Dental History

*Patient Name:*_____

*Date:*_____

New Smyrna
Cosmetic &
Family Dentistry
"Our Family Caring For Yours"

What is the reason for your appointment today? _____

Are you in any dental discomfort? _____

Who is your former dentist? _____Phone_____

What is the date of your last dental care?_____ Date of last x-rays?_____

Are you happy with your smile?_____

Is there anything about your smile that you would like to change?_____

Do you have a problem with any of the following?

Bad Breath	O Yes	O No
Bleeding Gums	O Yes	O No
Clicking or popping jaw	O Yes	O No
Food collection between teeth	O Yes	O No
Grinding or clenching teeth	O Yes	O No
Periodontal treatment	O Yes	O No
Adverse reaction to dental or medical care	O Yes	O No

Sensitivity to hot	O Yes	O No
Sensitivity to cold	O Yes	O No
Sensitivity when biting	O Yes	O No
Sensitivity to sweets	O Yes	O No
Loose teeth or broken fillings	O Yes	O No
Sores or growth in mouth	O Yes	O No
Other:_____		

Please list all of your current medications: **_____ I am not currently taking any medications**

_____

_____

_____

_____

_____

PLEASE SIGN AND DATE THE FOLLOWING:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of patient, parent or guardian **Date**