

**Dental History Form**

Why have you come to the dentist today? \_\_\_\_\_ Are you currently in pain? \_\_\_\_\_

Where is the pain/discomfort? \_\_\_\_\_ How long has it felt this way? \_\_\_\_\_ What brings on your symptoms? Please check all that apply: Cold \_\_\_\_\_ Hot \_\_\_\_\_ Biting pressure \_\_\_\_\_ Hurts on its own \_\_\_\_\_

Approximate Date of last dental visit? \_\_\_\_\_ Have you had major dental work in the past? \_\_\_\_\_

How do you prefer to get your teeth cleaned? Scaling with instruments or Ultrasonic with water (circle one)

Would you like a topical fluoride treatment today? **Not covered by insurance for adults (\$25)?** \_\_\_\_\_

Have you received any new crowns or fillings in the last month? \_\_\_\_\_

Are your teeth generally sensitive? \_\_\_\_\_ Please check all that apply: Cold \_\_\_\_\_ Hot \_\_\_\_\_ Sweets \_\_\_\_\_

Do you grind your teeth? \_\_\_\_\_ Do you have migraines? \_\_\_\_\_

Are you involved in any contact sports that could cause dental trauma? \_\_\_\_\_ Would you like a custom athletic mouth guard? \_\_\_\_\_

Do you have any black mercury fillings that show or concern you that you would like to change? \_\_\_\_\_

Do you have any crowns or caps that don't match your natural teeth or that you are unhappy with? \_\_\_\_\_

Are you satisfied with the appearance of your teeth? \_\_\_\_\_

Would you like Dr. Ortiz to discuss any cosmetic treatment with you such as veneers, whitening or Invisalign? \_\_\_\_\_

Have you ever lightened/bleached your teeth? \_\_\_\_\_ Do you have problems with bad breath? \_\_\_\_\_

Have you ever had any periodontal surgery? \_\_\_\_\_ Have you ever had root planing or deep cleanings? \_\_\_\_\_

Do your gums ever bleed? \_\_\_\_\_ How often do you brush/day? \_\_\_\_\_ Floss/week \_\_\_\_\_

What type of brush do you use (manual or electric)? \_\_\_\_\_ Are your brush bristles soft, medium or hard?

Are your cosmetic/aesthetic demands: High Medium Low

What is most important to you? Cosmetics Function Longevity

What is your anxiety level regarding dental treatment: Low Medium High

*For Dr.'s use ONLY*

**Recommend: Nitrous oxide  
Nitrous + oral sedation**

Reviewed by Dr. \_\_\_\_\_  
Date: \_\_\_\_\_

I understand the importance of being truthful with my doctor so that she may provide me with the best care possible. 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/dental status. After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

I understand that I am responsible for payment of services rendered and also responsible for paying any portions not covered by my dental insurance. Your portion is due at the time treatment is rendered.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_