Dental History

Why have you come to the dentist today? _____

Do you have any special concerns regarding your visit? _____

Are you aware of any problems? _____

When was your last dental visit? _____ What was done? _____

Previous Dentist name: _____ Phone Number: _____

When was your last cleaning? _____ X-rays? _____

Have you ever been diagnosed with Periodontal Disease (Gum Disease)? _____

Do you have or had any of the following:

Abscess in mouth	Yes ___ No ___	Difficulty Chewing	Yes ___ No ___	Loose Teeth	Yes ___ No ___
Any Food Traps	Yes ___ No ___	Bleeding Gums	Yes ___ No ___	Cold Sores	Yes ___ No ___
Dry Mouth	Yes ___ No ___	Sensitive Gums	Yes ___ No ___	Clench/Grind	Yes ___ No ___
Gags Easily	Yes ___ No ___	Pain in Ears/Face	Yes ___ No ___	Infected Gums	Yes ___ No ___
Bad Breath	Yes ___ No ___	Pain in Jaw Joint	Yes ___ No ___	Missing Teeth	Yes ___ No ___
Snore	Yes ___ No ___	Blisters	Lip ___ Mouth ___	Swelling (where)	_____

Smoke (how much) _____ Dip/Chew (how much)_____ Drink (how much) _____

Sensitive to: Hot _____ Cold _____ Sweets _____

What type of toothbrush do you use? (circle) Soft Medium Hard Electric

Are you happy with the way your smile looks? Yes ___ No ___

If not, what would you change? (circle) Shape Whiter Straighter Close the Gaps

Shorter Teeth Longer Teeth Less Crowded Mouth Other _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by Dr. Alvarado and staff to help determine appropriate and healthful dental treatment. I will notify Dr. Alvarado with any changes in my medical status. I authorize my insurance company to pay to Dr. Alvarado all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions. I authorize Dr. Alvarado to release all information necessary to secure payment on my behalf. I understand I am fully responsible for all charges whether covered or not or denied by my insurance company within 60 days.

Patient (Or Guardian's) Signature_____ Date _____