kneeland dental care

Dental History Form

Patient Name: First _____ MI ____ Last _____ Date of Birth _____

Reason for seeking dental care today? _____

Date of last cleaning or periodontal maintenance? _____ Date of last dental exam? _____ Date of last x-rays? _____

Are you experiencing any pain now? ☐ Yes ☐ No
If Yes, please describe: _____

Do you have, or have you had any of the following? (Check all that apply)

- ☐ Tooth sensitivity to hot/cold
- ☐ Broken tooth/teeth
- ☐ Broken filling
- ☐ Loose tooth/teeth
- ☐ Missing teeth
- ☐ Bleeding or swollen gums
- ☐ Areas of food traps
- ☐ Bad breath
- ☐ Grinding or clenching of teeth
- ☐ Difficulty opening wide
- ☐ Swelling in mouth
- ☐ Growths or lesions in your mouth
- ☐ Cold Sores
- ☐ Dry mouth
- ☐ History of trauma in head/neck region
- ☐ Previous/current orthodontic treatment
- ☐ Wear dentures
- ☐ Dissatisfaction w/appearance of teeth
- ☐ Had an unfavorable dental experience
- ☐ Other: _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? ☐ Yes ☐ No
If Yes, when: _____ Please describe treatment: _____

How often do you: Brush _____ times per day Floss _____ times per day

How do you feel about dental treatment? ☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very Anxious

Are you required to take antibiotic pre-medication prior to dental treatment? ☐ Yes ☐ No
If Yes, please explain: _____

General Information and Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform and administer any and all forms of treatment, medication, and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance, as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs, and records of any treatments or examinations rendered to my insurance company, consulting professionals, or others that may request my records.

I understand that before any work is performed, all treatment options will be discussed with me. Although rare, complications can arise during the course of treatment. Therefore, no guarantee, expressed or implied, can be given to me regarding the outcome of treatment.

Although their occurrence is rare and unpredictable, some risks are known to be associated with oral surgery, dental procedures, and associated anesthetics and medications. Such risks include but are not limited to: short and long-term numbness (paresthesia),

infection, aspiration and/or swallowing of dental materials, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, scarring, sensitivity in teeth or gums, and muscle or joint tenderness. I understand and accept that complications may require medical assistance and/or hospitalization. I also understand that during treatment it may be necessary to change or add procedures based on conditions found while working on the gums or teeth that were not previously discovered during initial examination. The most common added procedure we recommend is root canal therapy following restorative procedures. In rare cases during an extraction it may be necessary to refer the case to an oral surgeon for completion.

I certify that I have read and fully understand this consent form. I have been given the opportunity to ask questions regarding this consent and proposed treatment.

_____	_____	_____
Signature of patient or authorized responsible party	Print name	Date