NEW PATIENT DENTAL HISTORY

PATIENT NAME: ______________________________ DATE: ______________

Previous Dentist (name, city, state): ______________________________

Date of your last dental visit: ______________________________

- Reason for your last visit(s): ______________________________

Do you have any of your dental records and/or radiographs? ______________________________

- If not, do you know when your most recent set of dental x-rays was taken? ______________
  (you may want to obtain copies of your most recent records from your previous DDS)

How often do you brush your teeth? ______________________________

Do you use dental floss? . . . . . Yes / No If yes, how frequently? ______________________________

- Do your gums bleed or hurt when brushing or eating? . . . . Yes No
- Does food catch between any teeth? . . . . Yes No
- Have your teeth shifted – are there now spaces where there were none? . . . . Yes No
- Are any of your teeth loose? . . . . Yes No
- Do you feel your breath is sometimes offensive? . . . . Yes No
- Are any of your teeth sensitive to heat, cold or pressure? . . . . Yes No
- Do you have any pain or clicking around the jaw joint or your ear? . . . . Yes No
- Do you grind your teeth or clench your jaw? . . . . Yes No
- Do you have frequent head, neck or shoulder aches? . . . . Yes No
- Are there any sores or growths in your mouth? . . . . Yes No

Have you ever had any deep scaling or gum surgery? . . . . . . Yes / No If yes, why, where and when? ______________

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If you have lost teeth in the past, how and when were they replaced (Bridges/Crowns/Implants/Dentures)? ______________

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Do you have any other dental complaints or concerns? If so, please explain: ______________________________

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During any past dental treatment, have you ever . . .

Fainted? If yes, please explain: ______________________________

Had any abnormal bleeding? ______________________________

Had any allergic reactions to materials or medications? If yes, please explain: ______________________________

Had any other complications following dental treatment? If yes, please explain: ______________________________

Dentist's Signature ______________________________ Date ______________

PERMISSION TO RELEASE HEALTH INFORMATION

I grant the dentists and/or staff of Alpine Dental to release health information obtained from me, and information about my dental treatment to submit to third-party payers (medical/dental insurance). To request records from Alpine Dental, request separate form.

Printed Name of Patient ______________________________ Date ______________

Responsible Party Signature ______________________________ Relationship to Patient ______________