Robert L. Rodriguez, DDS

Patient Dental History

Patient's Name _____ **Date of Birth**_____

Reason for this visit_____

When was your last dental visit_____ What was done then_____

How often did you visit the dentist before then _____

Previous dentist (name and location) _____

Have you had a complete series of dental exams (x-rays) taken? When and where _____

How often do you brush your teeth _____ How often do you floss your teeth_____

Is your drinking water fluoridated _____

	YES	NO
Do your gums bleed while brushing or flossing_____	☐	☐
Are your teeth sensitive to hot or cold liquids/foods _____	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods_____	☐	☐
Do you feel pain to any of your teeth _____	☐	☐
Do you have any sores or lumps in or near your mouth ____	☐	☐
Have you had any head, neck, or jaw injuries_____	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking _____	☐	☐
Pain (joint, ear, side of face) _____	☐	☐
Difficulty in opening or closing_____	☐	☐
Difficulty in chewing_____	☐	☐
Do you have frequent headaches _____	☐	☐
Do you clench or grind your teeth _____	☐	☐
Do you bite your lips or cheeks frequently _____	☐	☐

	YES	NO
Have you noticed any loosening of your teeth _____	☐	☐
Does food tend to become caught between your teeth_____	☐	☐
Have you ever had periodontal treatment (gums)_____	☐	☐
Ever worn a bite plate or other appliance _____	☐	☐
Have you ever had any difficult extractions in the past_____	☐	☐
Have you ever had any prolonged bleeding following extractions _____	☐	☐
Do you wear dentures or partials _____	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums_____	☐	☐
Have you had ortho/braces in the past _____	☐	☐
Would you be interested in teeth whitening_____	☐	☐
Have you had an unfavorable dental experience _____	☐	☐
Do you snore?_____	☐	☐
Do you have sleep apnea?_____	☐	☐

If you could change anything about your smile, what would you change? _____

_____

_____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 2 working day notice. Once an appointment is made, please remember this time has been reserved for you.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Date_____

Signature of patient or parent if minor

Doctor's Comments_____

_____

_____**Signature**_____**Date**_____

_____

Patient Number