Dental History [continued]

9. Do your gums bleed on brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____
12. Are any of your teeth sensitive to heat, cold, or pressure? _____
13. Do you grind your teeth or clench your jaws? _____
14. Do you have pain or clicking in the jaw joint in front of your ear? _____
15. Have your jaw muscles ever been sore? _____ If yes, describe. _____
16. Are there any sores or growths in your mouth? _____
17. Do any of your teeth ache? _____
18. Do you have any other dental complaint? _____

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Patient's Initials _____ Dentist's Initials _____

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: _____ Signature _____

Witness _____ Print Name _____

If other than patient, indicate relationship _____ Date ____ / ____ / ____

Dentist's History Review & Significant Findings _____

Signature Dr. _____ Date ____ / ____ / ____