DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY ?_____

_____

_____

ARE YOU CURRENTLY IN PAIN ?	_____YES_____ NO
HAVE YOU EVER HAD SERIOUS / DIFFICULT PROBLEMS ASSOCIATED WITH ANY PREVIOUS DENTAL WORK ?	_____YES _____NO
DO YOU HAVE PAIN IN OR NEAR YOUR EARS ?	_____YES _____NO
ARE YOU AWARE OF GRINDING OR CLENCHING ?	_____YES _____NO
ARE YOUR TEETH SENSITIVE TO HOT OR COLD ?	_____YES _____NO
DO YOU OR HAVE YOU EVER EXPERIENCED PAIN OR DISCOMFORT IN YOUR JAW JOINT (TMJ) ?	_____YES _____NO
DO YOUR GUMS BLEED OR FEEL TENDER ?	_____YES _____NO
HAVE YOU EVER HAD NOVOCAINE ANESTHETICS ?	_____YES _____NO
HAVE YOU EVER HAD ANY REACTION TO NOVOCAINE ?	_____YES _____NO
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST ?	_____YES _____NO
WHEN WAS YOUR LAST FULL MOUTH X-RAY TAKEN ?	
WHERE WAS YOUR FULL MOUTH X-RAY TAKEN ?	

I UNDERSTAND THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PREFORM ANY NECESSSARY DENTAL SERVICES WITH MY INFORMED CONSENT THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT.

_____

SIGNATURE DATE

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. IT WILL ENABLE US TO HELP YOU MORE EFFECTIVELY. IF YOU HAVE ANY QUESTIONS AT THIS TIME, PLEASE ASK US. WE ARE HAPPY TO HELP.

DR. MARGARET A. BEAMER AND STAFF