Pacific Springs Dental

Patient Dental History

Name of previous dentist and location _____

Date of last exam _____

1. Do your gums bleed when brushing/flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids? Yes No
3. Are your teeth sensitive to sweet/sour foods? Yes No
4. Have you had any head, neck or jaw injuries? Yes No
5. Have you experience any of the following problems in your jaw?
    1. Clicking Yes No
    2. Pain (joint, ear, side of face) Yes No
    3. Difficulty in opening/ closing Yes No
    4. Difficulty in chewing? Yes No

6. Do you clench or grind your teeth? Yes No
7. Have you every had difficult extractions? Yes No
8. Have you had prolonged bleeding following extractions? Yes No
9. Do you have sores or lumps in or near your mouth? Yes No
10. Have you received instruction regarding the care of your teeth and gums? Yes No
11. Are you interesting in bleaching your teeth? Yes No
12. Is there anything you would like to improve about your smile? If yes, please explain

    _____

Authorization and release

I authorize the dentist to release any information including the diagnosis and 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 acutal bill for services. I acknowledge that if a predetermination is sent to my insurance carrier, that it is an estimate only. Payment is released to the dental office once a claim is received and processed based on the current benefits remaining on my plan. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent, if minor)