# DENTAL HISTORY AND CONSENT FOR TREATMENT

## NEW PATIENTS ONLY

Date of last dental visit ________ Reason? ________________ Date of last X-rays ________

Former dentist ____________________ City/state ____________________

How often do you: **Brush** _____ times per ________ **Floss** _____ times per ________

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Reason for seeking dental care at this time ______________________________

**Do you have or have you ever had any of the following? Please mark boxes and comment.**

| | | | |
|---|---|---|---|
| ☐Aching or sensitive teeth | ☐Broken filling | ☐Areas of food traps | ☐Unfavorable dental experience |
| ☐Sensitive or bleeding gums | ☐Loose teeth | ☐Difficulty opening wide | ☐Growths or lesions in your mouth |
| ☐Broken or missing teeth | ☐Bad breath | ☐Clicking or popping in jaw | ☐Cold sores |
| ☐Grinding or clenching | ☐Swollen glands | ☐Jaw pain or tiredness | ☐Dry mouth |
| ☐Swelling or lumps in mouth | ☐Gum infection | ☐Orthodontic treatment | ☐Other ________ |

**If you could change your smile, what would you change?**

| | | | |
|---|---|---|---|
| ☐Remove unsightly fillings | ☐Straighten teeth | ☐Change shape of teeth | ☐Close gaps between teeth |
| ☐Replace missing teeth | ☐Whitening | ☐Make teeth same color | ☐Other ________ |

## Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs, after discussed and agreed upon.

I also authorize the doctor to perform any dental treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate, after discussed and agreed upon.

______________________ ______________ ______________

Signature of patient or authorized responsible party | Relationship (to patient) | Date

______________________

Print Name