Family & Cosmetic Dentistry
Dental Smiles
At Dacula

Dental History

Date of Last Dental Exam: _____

Date of Last Full Mouth X-ray: _____ Where Taken: _____

	Yes	No
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around you mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had Nitrous Oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocaine, local, or general anesthesia?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Have you ever had a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Do you chew on only one side of your mouth? If so, why?		
16. Do you habitually clench or grind your teeth during the night or day?		
17. Is any part of your mouth sensitive to pressures or irritants (hot, cold, or sweets)?		

Is there any other problem not covered above that you would like to discuss?

_____

I understand that dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I requested and authorized. I understand that each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered to me and any associated financial matters. I agree to this covenant not to sue the corporation that employs the dentist or its shareholders regarding my dental care and associated financial matters.

_____ _____

Patient Signature Date Doctor Signature Date