



2133 Lawrenceville Suwanee Road, Suite 13, Suwanee GA 30024  
 Phone: (678) 377 6453, Fax: (678) 377 6483

**DENTAL HISTORY**

Date of Last Dental Exam: \_\_\_\_\_

Date of Last Full Mouth X-Rays: \_\_\_\_\_ 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 your 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 reactions or allergic symptoms to Novocain, local or general anesthesia?		
10. Have you ever had difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in the mouth or bad odor (foul smell) in the mouth?		
14. Have you ever had instructions on the care of your gums?		
15. Do you chew on one side of your mouth only? If so, why?		
16. Do you habitually clench or grind your teeth during night or day?		
17. Is any part of your mouth or teeth sensitive to pressure or irritants (Hot, Cold or Sweets)?		

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

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

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practice Representative Name & Signature: \_\_\_\_\_