DENTAL HISTORY

1. Reason for today's visit

2. Former Dentist City/State Phone Number

3. Date of last dental visit

4. Date of last x-rays

5. Have you ever had a full set of x-rays? □ YES □ NO If yes, when? _____

6. Have you ever had a panelipse x-ray (circles around your head)? □ YES □ NO

7. Do you have any dental problems or concerns at this time? □ YES □ NO
If yes, please explain

8. Are you in pain at this time? □ YES □ NO
9. Are your teeth sensitive? □ YES □ NO
If yes, to what? □ COLD □ HOT □ SWEETS □BITING/CHEWING □ BRUSHING

10. Do you frequently drink sodas or sports drinks? □ YES □ NO
11. Do you feel like you have a dry mouth? □ YES □ NO
12. Do you feel like you clench or grind your teeth? □ YES □ NO
13. Are you happy with the appearance of your teeth? □ YES □ NO
14. Do you have a tendency to gag? □ YES □ NO
15. Do you get frequent canker or cold sores? □ YES □ NO
16. Any problems with past dental treatment? □ YES □ NO
17. Do you consider yourself a nervous person? □ YES □ NO
18. Have you had any problems with local anesthetics? □ YES □ NO

19. Would you like to use nitrous oxide (laughing gas) during dental procedures?
** Note: There is a fee for the use of nitrous oxide. Unfortunately, it is usually not covered by insurance.
□ YES □ NO

20. Is there anything special we can do to make your dental experience more comfortable?
□ YES □ NO

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that his information will be used by Dr. Kashiwa, Dr. Chinn and their staff to determine appropriate dental treatment. I acknowledge that the questions have been answered to my satisfaction.

Signature of Patient /Guardian _____ Date _____