

Lowell Dental Care Dental History Form

DATE:	<i>HOW DID YOU HEAR OF US?</i>
--------------	--------------------------------

Name:	Home Phone:	Cell Phone:
Address:	City:	State: Zip:
Occupation	Date Of Birth:	Sex: M F E-mail:
SSN:	Emergency Contact:	Relationship: Contact Number:
If you are completing this form for another person, what is your name and relationship to that person?		

*Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. **Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.***

Dental Information

	Yes	No	?		Yes	No	?
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is your home water supply fluoridated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience dry mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping, or discomfort in the jaw?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any Periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any Orthodontic (braces) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a head, neck or mouth injury? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Do you wear partial or full dentures?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last Dental X-rays/ Exam? _____			
Have you ever had any problems with dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is the reason for your visit today? _____			
Are you experiencing any dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Are you happy with your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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 health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my Dentist, or any other member of his/ her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ **Date:** _____