YOUR FAMILY DENTIST
Micah Jeppesen D.D.S.

DENTAL HISTORY

Name of previous Dentist and Location_____
Date of last exam_____

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet/sour liquids/foods?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment (braces)?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Have you ever experienced any of the following problems? in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you like your smile?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

X_____
Signature of patient (or parent/guardian if minor)