



YOUR FAMILY DENTIST

— Micah Jeppesen D.D.S. —
— Palmer Jeppesen D.M.D. —

DENTAL HISTORY

Name of previous Dentist and Location _____
Date of last exam _____

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

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 than 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)