902 South 17th Street, Oskaloosa, IA 52577

Patient Dental History

1. In the morning, do you often wake up feeling tired?	Yes	No
2. Do you or have you been told that you snore?	Yes	No
3. Do you remember dreaming?	Yes	No
4. In general, are your teeth sensitive to hot, cold or sweets?	Yes	No
5. Do your gums bleed while brushing or flossing?	Yes	No
6. In general, do you feel pain to any of your teeth?	Yes	No
7. Do you have any sores or lumps in or near your mouth?	Yes	No
8. Have you ever experienced any of the following problems with your jaw? Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No
9. Do you grind or clench your teeth?	Yes	No
10. Do you bite your lips or cheeks frequently?	Yes	No
11. Have you ever had any difficult extractions?	Yes	No
12. Have you ever had any prolonged bleeding following an extraction?	Yes	No
13. Have you had any orthodontic (braces) treatment?	Yes	No
14. When did you last have your teeth cleaned?______________________		
15. As time goes by, our teeth tend to get darker. Would you be interested in restoring them to their original whiteness?	Yes	No
16. What would you change about your smile?_______________________		
17. Have you ever been told you need to take antibiotics prior to receiving treatment?	Yes	No
18. If yes, antibiotic_____________ preferred pharmacy_______________		

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions and questions on the reverse side have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 payers and/or healthcare practitioners (this applies to those with dental insurance except for Blue Dental and Wellmark BC/BS since we are not participating providers for these insurance companies). I authorize and request my insurance company to pay dental benefits directly to the dentist, or dental group (this applies to those with dental insurance except for Blue Dental and Wellmark BC/BS of Iowa.) I understand that my dental insurance carrier may pay less than the actual charge for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependants.

____ Date_________

Signature of patient (parent/guardian if minor)

Doctor's comments____

Doctor's signature _______________________ Date_________