



## Dental History

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  Yes  No

Have you ever required antibiotics before dental treatment?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you floss daily?  Yes  No Brush daily?  Yes  No

Type of toothbrush?  Manual  Battery  Electric  Sonic

Are you satisfied with the appearance of your smile?  Yes  No

If No, what would you like to change: *(circle those that apply)*

Length of teeth, color, spaces, crowding, other: \_\_\_\_\_

Have you ever had any serious complications with prior dental treatment?  Yes  No

If yes, what? \_\_\_\_\_

Have you had any head, neck or jaw injuries?  Yes  No

Do you have frequent headaches?  Yes  No

Do your gums ever bleed?  Yes  No

Have you ever had periodontal disease?  Yes  No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you have any loose teeth?  Yes  No

Previous / Present Dentist \_\_\_\_\_ Last Visit Date \_\_\_\_\_  
*(Please Circle)*

Why did you leave your last dentist? \_\_\_\_\_

Have you ever experienced any of the following problems in 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

Do you clench or grind your teeth?  Yes  No

Have you had any orthodontic work (braces)?  Yes  No

Have you ever whitened your teeth?  Yes  No

If yes, what type of product? \_\_\_\_\_

COMFORT QUESTIONNAIRE	<i>For each of these questions, circle the number under the word or phrase that best describes your feelings.</i>				
	Relaxed	A Little Uneasy	Tense	Anxious	Very Anxious
If you had to go to the dentist tomorrow, how would you feel about it?	1	2	3	4	5
Imagine you are waiting in the dentist's office for your turn in the chair. How do you feel?	1	2	3	4	5
Imagine you are sitting in the dentist's chair as she prepares to give you a shot. How do you feel?	1	2	3	4	5
Imagine you are sitting in the dentist's chair as she prepares the drill to work on your teeth. How do you feel?	1	2	3	4	5
Imagine you are waiting in the hygienist's chair and he/she is getting the instruments used to scrape your teeth. How do you feel?	1	2	3	4	5

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient) \_\_\_\_\_ and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.

I hereby give my permission to Wilsonville Dental Group P.C. to release my dental records to my insurance company, specialists I may be referred to or others to whom I may request my records be sent.

I understand that responsibility for payment for dental services provided in the office for myself and/or my dependents is mine and not my insurance company, my employer or any other third party. Arrangements for payment will be made before initial treatment begins. Breach of this responsibility carries the penalty of compensating the doctor(s) for attorney's and collection fees. I understand that, where appropriate, credit bureau reports may be obtained.

I agree and understand that any and all legal disputes related to the services of Wilsonville Dental Group or affiliates shall be determined by submitting to binding arbitration.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN (RELATIONSHIP)