JONATHAN THOMAS DDS
Smiles with Aloha

PATIENT DENTAL HISTORY

WHAT PROMPTED YOU TO CONTACT OUR OFFICE FOR AN APPOINTMENT?________________________________

HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH DENTISTRY? ◯ YES ◯ NO

DOES DENTAL TREATMENT MAKE YOU NERVOUS? ◯ YES ◯ NO

DO YOU USE THE FOLLOWING

TOOTHBRUSH ◯ YES ◯ NO HOW OFTEN?________________________

DENTAL FLOSS ◯ YES ◯ NO HOW OFTEN?________________________

OTHER ORAL HYGIENE DEVICE ◯ YES ◯ NO WHAT & HOW OFTEN?________________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

LOOSE TEETH ◯ YES ◯ NO HOW LONG?________________________

BAD BREATH ◯ YES ◯ NO HOW LONG?________________________

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING ◯ YES ◯ NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS ◯ YES ◯ NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS ◯ YES ◯ NO
4. DO YOU FEEL PAIN ON OR AROUND YOUR TEETH ◯ YES ◯ NO
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH ◯ YES ◯ NO
6. HAVE YOU EVER HAD ANY HEAD, NECK OR JAW INJURIES ◯ YES ◯ NO
7. HAVE YOU EVER HAD CLICKING IN YOUR JAW ◯ YES ◯ NO
8. HAVE YOU EVER HAD DIFFICULTY OPENING OR CLOSING YOUR JAW ◯ YES ◯ NO
9. HAVE YOU EVER HAD DIFFICULTY CHEWING ◯ YES ◯ NO
10. DO YOU HAVE FREQUENT HEADACHES ◯ YES ◯ NO
11. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY ◯ YES ◯ NO
12. HAVE YOU HAD PROLONGED BLEEDING FOLLOWING EXTRACTION ◯ YES ◯ NO
13. HAVE YOU EVER HAD ORTHODONTIC TREATMENT ◯ YES ◯ NO
14. DO YOU WEAR DENTURES OR PARTIALS ◯ YES ◯ NO
15. DO YOU HAVE EAR OR SIDE OF FACE PAIN ◯ YES ◯ NO
16. DO YOU HAVE JOINT PAIN ◯ YES ◯ NO

1. ON A SCALE OF 1-10 (1 BEING TERRIBLE AND 10 BEING PERFECT) HOW HEALTHY DO YOU THINK YOUR MOUTH IS?____________________
2. ON A SCALE OF 1-10 (1 BEING TERRIBLE AND 10 BEING PERFECT) HOW HEALTHY WOULD YOU LIKE YOUR MOUTH TO BE?____________________
3. ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?

IF YOU ANSWERED NO AND YOU COULD INSTANTLY CHANGE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH, WHAT WOULD YOU CHANGE?
____

4. WHAT ARE SOME QUESTIONS ABOUT DENTISTRY AND YOUR ORAL HEALTH THAT YOU HAVE NEVER HAD ADEQUATELY ANSWERED?
____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE KNOWLEDGE TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS 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 RECORDS TO THIRD PARTY PAYORS. 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 OR MY DEPENDENTS.

DATE:____________________