# DECK DENTISTRY | Your Dental History

Name _____ _____ _____ Date of Birth ___ / ___ / ___
Surname First Name(s) Your Preference D M Y

What concerns you most about your dental health? _____

Are you having pain at this time? ☐ Yes ☐ No If yes, describe where _____

Do you see a dentist on a routine basis? ☐ Yes ☐ No Date of your last dental visit? _____

How do you rate your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had an upsetting experience in a dental office ☐ Yes ☐ No If so, describe _____

Have you ever had any of the following? ☐ Oral Surgery ☐ Braces ☐ Bite Plate/Night guard
☐ Dental Implants ☐ Periodontal (Gum) Surgery

Have you experienced any of the following? ☐ Pain or swelling in your gums ☐ Loosening of your teeth
☐ Clicking or locking of your jaw ☐ Pain in your jaw or jaw joint
☐ Difficulty opening or closing your mouth
☐ Sore spots or burning sensations in your mouth ☐ Bad breath

Do you have any of the following habits? ☐ Clenching or grinding (awake or asleep) ☐ Hold/bite foreign objects
☐ Bite your lips or cheeks ☐ Mouth breathe

Do you gag easily? ☐ Yes ☐ No Do you experience "Dry Mouth"? ☐ Yes ☐ No

Are you concerned about the appearance of your teeth? ☐ Yes ☐ No

If so, what would you like to see changed? _____

Insurance companies now only allow for "*functionally acceptable work*". In the past their coverage was for "*quality work*". It is our desire to provide our patients with the highest quality work within their financial capabilities and expectations.

What is important to you? (check one) ☐ The highest quality dentistry available
☐ The most economical treatment plan
☐ Dentistry limited to my insurance coverage

☐ A combination of the above, please explain:_____

**I, the undersigned, hereby authorize the Dentist to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of my dental needs.**

**I also authorize the Dentist to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with** *(name of Patient)* _____ **after discussion and consultation between the named patient (or guardian of) and the dentist, including alternative options or the consequences of no treatment. I also understand the use of anesthetic agents involves a certain risk.**

Patient (*Parent or Guardian*) Signature _____ Date _____

Dentist's Signature _____