Dental History

DENTALCARE
ROLAND L. ELAZEGUI, DMD, INC.

Patient Name *First* ________________ *Last* ________________

Primary Reason for Today's Visit ________________ Date of last Dental X-Ray ________

Last Dental Visit Date ________ Former Dentist ________________ Dentist Phone (____) ____ - ____

1 Is this visit for Emergency Dental care? .... Yes No
If yes, please explain: ________________
2 Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
3 Have you ever had any unfavorable reactions from a local anesthetic? .... Yes No
4 Have you had any serious complications associated with any previous dental treatment? .... Yes No
If yes, please explain: ________________
5 Have you had any unhappy/unpleasant dental experiences? .... Yes No
If yes, please explain: ________________
6 Have you had any orthodontic treatments? .... Yes No
7 Do you currently have any dental implants, dentures, or partials? .... Yes No
8 Do you easily gag? .... Yes No
9 Does your jaw get "stuck," "locked," or "go-out"? .... Yes No
10 Do you have any oral habits (thumb sucking, nail biting, or biting on foreign objects - pencils, etc.)? .... Yes No
11 Does dental treatment make you nervous? Not at all Slightly Moderately Extremely

Have you ever suffered from, or been told you may have one of the following? Please check all that apply.

Bad Breath	Gum Disease	Pain in the Mouth
Bleeding Gums	Headaches or Migraines	Sleep Apnea
Clicking / Popping Jaw	Jaw Pain / TMJ Pain	Snoring
Difficulty Swallowing	Malocclusion	Sore Throat
Dry Mouth	Mouth Breathing	Sores / Growth in the Mouth
Grinding or Clenching	Pain in or near your ears	Tooth Sensitivity to Cold/Hot

The most important concerns regarding my dental treatment are: ________________

Any additional comments/questions: ________________

I have reviewed the information on this questionnaire and it is accurate and complete to the best of my knowledge.
I understand that this information will be used by the dentist to help determine appropriate dental treatment.

Patient Signature ________________ Date ________

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient, whose name appears on this health history form, to administer such anesthetics, analgesics, nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics, and/or drugs.

Patient Signature ________________ Date ________

Relationship to patient (if patient is a minor) ________________