Coastal Dental Services <<<>>> Dentures & *More*

Southside Office
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Confidential Personal Information and Medical & Dental History Form ***(Page 3 of 5)***

DENTAL TREATMENT HISTORY & QUESTIONNAIRE

Patient: ____ File #: ________________

1) Name & location of previous Dentist ____

2) Date of your last dental treatment: __________. Treatment rendered: ______________________

3) Treatment recommended: ____

YES NO Do you have any bumps, swellings, bruises, sore areas, pain/discomfort anywhere in/around your head, ears, or neck?

YES NO Have you ever been advised that you have Periodontal Disease (gum disease) or recommended to have gum treatment?

YES NO Have you ever had dental treatment recommended that was not done?

YES NO Do you have bleeding gums or any other gum condition?

YES NO Do you have any broken teeth or retained/residual roots that you believe require removal?

YES NO Have you ever had complications from any dental extraction or surgery?

YES NO Have you ever been advised to have dentures?

YES NO Are you experiencing dental pain at this time?

YES NO Are there any growths or sores in your mouth at this time?

YES NO Are you having trouble chewing?

YES NO Do you have pain in or near your ears?

YES NO Do you have aching muscles in your cheeks, temples or forehead?

YES NO Do you habitually clench or grind your teeth during the day or night while sleeping?

YES NO Do you feel very nervous about having dental treatment?

YES NO Have you had a bad experience in the dental office?

State in your own terms the purpose of seeking a dental examination and treatment by this office:

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If there is anything related to your Medical or Dental treatment or history that you have not indicated above, or if you have any additional comments or information, or if you need additional space to answer any question on this or the Confidential Medical History form, please use the additional sheet to write a brief narrative.

By signing this form I authorize release of medical information to associated medical/dental providers, insurance companies of which I am an insured, &/or other entities legally authorized by Florida State Law to possess my medical/dental treatment & condition records.

Signature:___________________________________ Date:________________