

DENTAL HISTORY FORM

Welcome! Please fill out the form below as completely as you can. The information on this form will be used to determine the appropriate dental treatment. You may submit the completed form on our secure URL site, print and bring to your next appointment, or fax to online (303) 773-9518.

1. What is the reason for your visit today?

Please explain:

2. How long has it been since your...	Never	6 months	1 year	2 years	Greater than 2 years
Last dental visit?					
Last dental cleaning?					
Last set of full mouth x-rays?					
3. How many times each day do you...	0x	1x	2x	3x	4+ per day
Floss your teeth?					
Brush your teeth?					
Use a dental aid (Interplak, toothpick, etc)?					

4. Please provide the following information about your prior dentist:

Name:	Street Address:		
City:	State:	Zip:	
Phone Number:			

5. On average, how often do you visit a dentist each year?

0 Once Twice Three times Four or more times

6. Are you currently experiencing any dental health problems you would like us to address? Yes No

If yes, please explain:

7. What are your main concerns regarding your visits? (check all that apply)

Anxiety Cost Time Other, please explain:

8. Typically, how would you describe your past dental experiences?

Excellent Good Fair Poor Other, please explain:

9. Have you had any negative dental experiences? Yes No

If yes, please explain:

10. Are you satisfied with the appearance of your teeth? Yes No

please explain:

11. What are the main objectives you would like to accomplish with your dental treatment?

please explain:

12. Are any of your teeth sensitive to...	(Yes)	(No)	Additional Information:
Sweets?			
Hot or cold?			
Biting or chewing?			
13. Have you experienced...	(Yes)	(No)	Additional Information:
Headaches?			
Dry mouth?			
Bleeding gums?			
Bad breath or bad tastes?			
Clicking or popping of the jaw?			
Sore muscles (neck, shoulders)?			
Pain in the joint, ear, or side of face)?			
A serious injury to the mouth or head?			
Difficulty opening or closing the mouth?			
Blisters, cold sores, or other oral lesions?			
Difficulty chewing on either side of the mouth?			
14. Do you....	(Yes)	(No)	Additional Information:
Gag easily?			
Bite your nails?			
Drink alcohol?			How much per day?
Chew tobacco?			How many per day?
Smoke tobacco?			How much per day?
Bite your lips or cheeks regularly?			
Mouth breath while awake or asleep?			
Have tired jaws, especially in the morning?			
Frequently get food stuck between you teeth?			
Have a history of gum disease in your family?			
Clench or grind your teeth while awake or asleep?			
Hold foreign objects with your teeth (pencils etc)?			
15. Have you ever had...	(Yes)	(No)	Additional Information:
Oral surgery?			Please describe:
Periodontal treatment?			
Orthodontic treatment?			
A bite plate or mouth guard?			
Your teeth ground or the bite adjusted?			

Please use the space below to for additional questions or concerns:	
I give Dr. Amundson consent to use local anesthetic as needed. I agree I disagree	
Name:	
Signature:	Date:
<p>I have reviewed the information on this form and it is accurate to the best of my knowledge.</p> <p>I understand that this information will be used by Dr. Peter Amundson and his staff to help determine appropriate and healthful dental treatment. If there is any changes in my medical status, I will inform Dr. Peter Amundson. Since at each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun I give Dr. Peter Amundson my consent to perform any needed dental treatment.</p> <p>I authorize my insurance company to pay Dr. Peter Amundson all insurance benefits otherwise payable to me for services rendered I authorize the use of this signature on all insurance submissions.</p> <p>I authorize Dr. Peter Amundson to release all information necessary to secure the payment of benefits.</p> <p>I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.</p> <p>When you arrive for your appointment we will have you sign and date your Medical and Dental History as required by law.</p>	
Name:	
Signature:	Date: