Westside Dental Center **John A. Shuffield, D.D.S., P.L.L.C.**

Patient Dental History

Name of Previous Dentist and Location _____

Date of Last Exam_____

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 to any of your teeth?	Yes / No
5. Do you have any sores or lumps in or near your mouth?	Yes / No
6. Have you had any head, neck or jaw injuries?	Yes / No
7. Have you experienced any of the following problems in your jaw?	
Clicking	Yes / No
Pain (joint, ear, side of face)	Yes / No
Difficulty in opening or closing	Yes / No
Difficulty in chewing	Yes / No
8. Do you have frequent headaches?	Yes / No
9. Do you clench or grind your teeth?	Yes / No
10. Do you bite your lips or cheeks frequently?	Yes / No
11. Have you ever had any difficult extractions in the past?	Yes / No
12. Have you ever had any prolonged bleeding following extractions?	Yes / No
13. Have you had any orthodontic treatment?	Yes / No
14. Do you wear dentures or partials?	Yes / No
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes / No
16. Do you like your smile?	Yes / No

Authorization and Release

I certify that I have read and understand the above information 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 the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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.

Signature of patient (or parent/guardian if minor)