CHRYSALIS DENTAL

DENTAL HISTORY

1. You are here today for: Check-up:_________ Cleaning:_________ Toothache:_________

   Chief Complaint: ____

2. When did you last visit a dentist? _____________ Name of Dentist?___________________________

   What treatment was performed:____

3. When was your last full set of X- rays taken? _________________________________

   Would you like us to request recent x-rays? Yes__________ No__________

4. Have you ever had prolonged bleeding after an extraction? Yes__________ No__________

   If yes, please explain:____

5. Have you had any problems with past dental treatment? Yes__________ No__________

   If yes, Please specify: ____

6. Do you have any problems associated with movement of the lower jaw such as, clicking, popping, pain or locking when open? Yes__________ No__________

   If yes, please specify____

7. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction, sometimes called TMD)? Yes__________ No__________

   If yes, please specify____

8. Do your gums bleed easily? Yes _________ No__________

9. Do you feel you have bad breath? Yes__________ No__________

10. Are your teeth sensitive to hot and cold? Yes__________ No__________

11. Would you like your teeth whiter? Yes__________ No__________

12. Are there any cosmetic changes you would like to have done? Yes__________ No__________

If yes, please explain ____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of X-rays and oral examination.

____ ______________________________

Signature of Patient / Parent Date