Russell L. Casement DDS, Kelley A Casement DDS

DENTAL HISTORY

PATIENT NAME_____ BIRTH DATE_____
WHOM MAY WE THANK FOR REFERRING YOU?_____

1. Do you feel pain to any of your teeth?	O Yes O No
2. Are your teeth sensitive to hot or cold liquids/foods?	O Yes O No
3. Are your teeth sensitive to sweet or sour liquids/foods?	O Yes O No
4. Do your gums bleed while brushing?	O Yes O No
5. Do you have sores or lumps in or near your mouth?	O Yes O No
6. Have you ever experienced any of the following problems in your jaw?	O Yes O No
1. Clicking?	O Yes O No
2. Pain (joint, ear or side of face)?	O Yes O No
3. Difficulty in opening or closing?	O Yes O No
4. Difficulty in chewing?	O Yes O No
7. Do you clench or grind your teeth?	O Yes O No
8. Do you bite your lips or cheeks frequently?	O Yes O No
9. Have you ever had any difficult extractions in the past?	O Yes O No
10. Have you ever had prolonged bleeding following extractions?	O Yes O No
11. Are you wearing any removable appliances (ex. Dentures)?	O Yes O No
12. Have you ever had any orthodontic work?	O Yes O No
13. Have you ever been told you have periodontal disease?	O Yes O No
14. Have you ever had instructions on the correct method of brushing your teeth?	O Yes O No
15. Have you ever had instructions on the care of your gums?	O Yes O No

COMMENTS: _____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to Inform the dental office of any changes in status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE_____