DENTAL HISTORY

Reason for your visit today?

Previous Dentist (Name and Location):

How often do you brush your teeth? How often do you floss your teeth?

Question			Question		
Is your drinking water fluoridated?	YES	NO	Do you have pain in any of your teeth?	YES	NO
Do your gums bleed when brushing or flossing?	YES	NO	Do you experience jaw clicking?	YES	NO
Are your teeth sensitive to cold?	YES	NO	Do you experience jaw pain?	YES	NO
Are your teeth sensitive to hot?	YES	NO	Do you experience difficulty opening or closing?	YES	NO
Are your teeth sensitive to sweet?	YES	NO	Do you have difficulty chewing?	YES	NO
Do you use a CPAP machine?	YES	NO	Do you bite your lips or cheeks frequently?	YES	NO
Do you clench or grind your teeth?	YES	NO	Have you noticed loosening of your teeth?	YES	NO
Does food tend to become caught between your teeth?	YES	NO	Have you had difficult teeth extractions in the past?	YES	NO
Have you had periodontal gum treatment?	YES	NO	Have you ever had any prolonged bleeding following extractions?	YES	NO
Have you worn a bite guard or other dental appliance?	YES	NO	Do you wear dentures or partials?	YES	NO

Is there anything about your smile you would like to change? YES NO
Explain, if yes:

Notice of Privacy Practices

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy, which are outlined in the HIPAA form available upon request. This information will be used to:

1. **Plan, conduct and direct your treatment and follow-up among multiple health care providers involved in your treatment.**
2. **Obtain payment from third party payers (insurance companies).**
3. **Conduct normal healthcare operations such as quality assessment and physician certification.**

You have the right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. Firlik Family Dentistry has the right to change its Notice of Privacy Practices from time to time and you may contact us at any time to obtain a copy of the Notice of Privacy Practices.

Patient Name: ____

Patient or Guardian Signature: ____

Relationship to Patient if Patient is a Minor: ____________________________________

Date: ____________________________

I give Firlik Family Dentistry permission to share information regarding my dental care to:

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