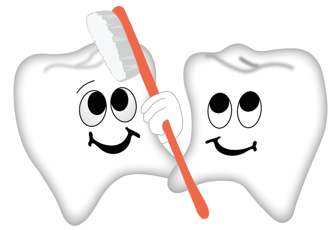
DENTAL HISTORY AND CONSENT FOR TREATMENT



Robert H. Everett DMD, PC

Reason for seeking dental care at this time? ____________________

Date of last dental visit __________ Reason for visit / what was done? ____________________

Former dentist ____________________ City __________ State ______ Zip ______

Phone ____________________ Date of last x-rays ____________ Date of last cleaning ____________

How do you feel about dental treatment? ☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very anxious

Do you like any of the following during a dental appointment? ☐ Blanket ☐ Pillow ☐ Headphones ☐ Oral sedation

Do you have or have you ever had any of the following?

- ☐ Aching or sensitive teeth
- ☐ Teeth sensitive to cold
- ☐ Teeth sensitive to sweets
- ☐ Teeth sensitive to biting
- ☐ Sensitive or bleed gums
- ☐ Broken or missing teeth
- ☐ Grinding or clenching
- ☐ Swelling / lumps in mouth
- ☐ Broken filling
- ☐ Loose teeth
- ☐ Bad breath
- ☐ Swollen glands
- ☐ Gum infection
- ☐ Areas of food traps
- ☐ Difficulty opening wide
- ☐ Jaw pain or tiredness (During dental treatment)
- ☐ Orthodontic treatment
- ☐ Bad dental experience
- ☐ Dry mouth
- ☐ Frequent headaches
- ☐ Treatment for TMD (TMJ)
- ☐ Other ____________

If you could change your smile, what would you change?

- ☐ Remove unsightly fillings
- ☐ Replace missing teeth
- ☐ Straighten teeth
- ☐ Whitening
- ☐ Change shape of teeth
- ☐ Make teeth same color
- ☐ Close gaps between teeth
- ☐ Other ____________

Can you chew on both sides of your mouth? ☐ Yes ☐ No Can you eat all the foods you like? ☐ Yes ☐ No

Is there anything you would like us to know to help make your dental experience as comfortable as possible? ____________________

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Dr. Everett is a member of a study club with some of the top dental specialists in the Portland area. The study club dentist include specialists in the areas of oral surgery, crown and bridge, orthodontics and dental implants. I agree to improve patient care by allowing my dental record to be shared with other dental colleagues. My identity will always be kept confidential. ☐ Yes ☐ No

I certify that the above information is true, accurate and complete. My signature below authorizes Dr. Everett or his staff to take radiographs (x-rays), impressions for study models, photographs or any other diagnostic aid(s) deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to preform any and all forms of treatment and therapy that may be indicated or prescribe medications as needed. I authorize and consent that Dr. Everett employs any such assistance as he deems appropriate to provide my dental treatment.

Signature ______________________________ Date ______________

Printed name ______________________________