

Patient Name _____

Name and location of previous dentist _____

Date of last exam _____

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| 1. Do your gums bleed while brushing?..... Yes / No | 8. Do you have frequent headaches?..... Yes / No |
| 2. Are your teeth sensitive to hot or cold liquids or food?..... Yes / No | 9. Do you clench or grind your teeth?..... Yes / No |
| 3. Are your teeth sensitive to sweet or sour liquids or food?..... Yes / No | 10. Do you bite your lips or cheeks frequently?..... Yes / No |
| 4. Do you feel pain in any of your teeth?..... Yes / No | 11. Have you ever had difficulty with extractions in the past?..... Yes / No |
| 5. Do you have any sores or lumps in or near your mouth?..... Yes / No | 12. Have you ever had any prolonged bleeding following extractions?..... Yes / No |
| 6. Have you had any head, neck or jaw injuries?..... Yes / No | 13. Have you ever had orthodontic treatment?..... Yes / No |
| 7. Have you ever experienced any of the following problems in your jaw?..... Yes / No | 14. Do you wear dentures or partials? Yes / No
If yes, date of placement _____ |
| Clicking?..... Yes / No | 15. Have you ever received hygiene instructions regarding the care of your teeth and gums?..... Yes / No |
| Pain (joint, ear, side of face)?..... Yes / No | 16. Do you like your smile?..... Yes / No |
| Difficulty in opening or closing?..... Yes / No | |
| Difficulty in chewing?..... Yes / No | |

Authorization and Release

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 Dr. Fankhauser to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Fankhauser, to make a thorough diagnosis of my dental needs.

I authorize Dr. Fankhauser to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payer and/or health practitioners.

I authorize Dr. Fankhauser to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Fankhauser choose and employ such assistance as deemed necessary.

Patient's(parent/guardian if minor) signature _____ date _____

