Joshua Nellis, DDS
THE WOODLANDS DENTIST

HEALTH HISTORY

Patient Dental History

Patient's Name _____ Date of Birth _____

Reason for this visit _____

When was your last dental visit? _____ What was done? _____

Previous Dentist Name (name and location) _____

Have you had any dental x-rays taken in the last 6 months? _____

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

	YES	NO
Do your gums bleed while flossing or brushing?	☐	☐
Do you feel pain with any of your teeth?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw:		
Clicking	☐	☐
Pain (Joint, Ear, Side of Face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you snore or have you been told you snore?	☐	☐
Have you been diagnosed with sleep apnea?	☐	☐
Do you use a CPAP machine or have you been told you need a CPAP machine?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Have you ever had periodontal treatment (gums)?	☐	☐
Ever worn a night guard or splint?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement	_____	

Is there anything about your smile you don't like? _____

Do you like the appearance of your smile? _____

Are your teeth all in alignment (straight)? _____

Do you have missing teeth? _____ Are any chipped? _____

Is your bite comfortable for chewing, biting? _____

Do you have frequent headaches? _____

Do you have old fillings or dental work you don't like? _____

What would you like to change the most in the appearance of your teeth? _____

Are you aware of the new techniques in dentistry? _____

What is most important to you in a dental office _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered, I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Parent/Guardian _____ Date _____