Patient Dental History

Twin Cities SEDATION

Patient Name: _____

Parent/Guardian Name (if minor): _____

Email Address: _____

Why are you seeking sedation dentistry? _____

_____

Have you seen a mental health professional regarding your anxiety or fear of dental treatment? YES NO

Have you ever been diagnosed with an anxiety disorder? YES NO

Is there anything else you would like us to know to help your appointment go more smoothly? YES NO

If yes, what?: _____

Name of Previous Dentist: _____ Emergency contact Information

Date of Last Dental Exam: _____ Name: _____

Date of Last Dental Cleaning: _____ Phone number: _____

Cleaning Frequency: _____ Relationship to Patient: _____

How you hear about our office?_____ Preferred Pharmacy:_____

Have you ever been told you have gum or periodontal disease **YES** **NO**

If yes, have you had treatment? YES NO If yes, when: _____

Do you have a family history of any of the following conditions?:

Diabetes, including gestational YES NO

Periodontal Disease YES NO

Have you had or are you currently experiencing any of the following?

Sensitive teeth?	YES	NO
Pain in your mouth?	YES	NO
Sores or lumps in or near your mouth?	YES	NO
Clicking, popping, or other difficulty with your jaw?	YES	NO
Head, neck, or jaw injuries?	YES	NO
Difficult extractions in the past?	YES	NO
Orthodontic treatment?	YES	NO
Have a denture or a partial denture?	YES	NO