



**DENTAL HISTORY**

**DATE:** \_\_\_\_\_  
MM / DD / YY

**MEDIC ALERT** \_\_\_\_\_

1. When was your last visit to a dental office? \_\_\_\_\_
2. What dental problem concerns you at the present time? \_\_\_\_\_  
\_\_\_\_\_
3. Do you have a problem with local anaesthetic (freezing)?..... Yes  No
4. Are you worried about receiving dental treatment?..... Yes  No
5. Do your gums bleed when you brush or floss?..... Yes  No
6. Are your teeth sensitive to hot, cold, sweets or touch?..... Yes  No
7. Is bad breath or a bad taste in your mouth a concern?..... Yes  No
8. Do you have sores or swelling in or around your mouth?..... Yes  No
9. Do you clench or grind your teeth?..... Yes  No
10. Do you have any jaw (joint) problems (clicking / popping / difficulty opening or closing your mouth?..... Yes  No
11. Do you suffer from headaches?..... Yes  No
12. Do you wear a dental appliance?..... Yes  No
13. Do you gag easily?..... Yes  No
14. Are you interested or have you ever thought of : (Please check )  
 Whitening       Crowns       Veneers       Closing spaces between teeth       Replacing missing teeth
15. Is there anything regarding your medical or dental history that we have not discussed; which would be important for us to know prior to treatment?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. Would you be interested in esthetics and cosmetic procedures?  
a) Non surgical skin rejuvenation with light and lasers?  Yes  No  
b) Injectables (botox / fillers)?  Yes  No

**You are responsible for all financial obligations for your dental care services.**

**I authorize routine diagnostic and major procedures, and if I accept the proposed program, I agree to the use of anaesthetics and pre-medications as considered necessary or advisable by the dentist responsible for this service.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**NOTES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LASER CONSENT – RISKS AND DISCOMFORTS**

During laser treatment, you may find there is an offensive odor and a popping sound. You may also experience minor discomfort. Possible damage to the unprotected eye can occur when exposed to direct or reflective laser light. Therefore, you will be required to wear appropriate protective goggles during all laser treatments. If the area of therapy does not respond, a referral to a specialist may be recommended.

I have read the foregoing and have asked and received responses to any questions which I may have regarding the risks associated with the use of lasers.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**