Newbury Park
DENTAL ARTS

DENTAL HISTORY

please indicate an answer for each general question

How often do you brush? ______________________ How often do you floss? ______________________

Toothpoaste you use: ______________________ Mouthwash you use: ______________________

Other oral health care aids you currently use (waterpik, electric toothbrush, tongue scraper, etc.)

____

Date of last Dental Exam: ______________________ Date of last clening: ______________________

Do you currently have any dental pain? YES NO if yes, where: ______________________

if yes to above, is this pain: Sporadic Constant Dull Sharp

Do you have any other current dental concerns / Comments ?

Do you now, or have you ever (Please select)

Grind Teeth:

Bite Cheek:

Tongue Thrust:

Mouth Breather:

Bulimia/ Anorexia:

Cigar / Cigarette:

Pipe:

Bite Nails:

Smokeless Tobacco:

Thumb / Finger:

Toothpick / Stimulator:

Chewing Gum:

Candy:

Soft Drinks:

Are your teeth senitive to: (please select)

Hot or Cold:

Biting / Chewing:

Sweets:

Have you ever had: (please select)

Orthodontic Treatment:

A bite plate of guard:

Periodontic Treatment:

Oral Surgery:

Serious injury to mouth or head

Is there anything about your teeth or smile that you dont like or would like to change?

Is there anything else about your teeth or dental history that you want us to know?

CONSENT FOR MYSELF OR MINOR PATIENT:
The undersigned hereby authorizes Dr. Markiewicz and employees to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Markiewicz to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Markiewicz to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with above referenced patient and further authorize and consent that Dr. Markiewicz choose and employ such assistance she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

**SIGNATURE OF PATIENT,
PARENT OR GUARDINAN** ______________________ **DATE:** __________ **WITNESS:** __________