DENTAL HISTORY

What prompted you to make this appointment? What concerns do you have?

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

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Date of last Dental Visit: ____________________ Reason for Visit: ____________________

YES	NO	Please explain all "YES" answers
☐	☐	Have you had a reaction to local anesthetic? ____________
☐	☐	Have you experienced nitrous-oxide sedation? ____________
☐	☐	Have you had prolonged bleeding or complications from previous dental procedures? ____________
☐	☐	Do you have any sore areas in your mouth or on your body that have been there over 10 days? ____________
☐	☐	Have you had orthodontics (braces, Invisalign, etc.) in the past?
☐	☐	Have you ever had clicking, popping or pain associated with your jaw joint(s)?

I hereby state that the above information is correct and complete.

SIGNED, PATIENT (OR PARENT IF MINOR)	DATE	SIGNED, DDS

SLEEP APNEA

YES	NO	
☐	☐	**Snoring?** Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
☐	☐	**Tired?** Do you often feel **Tired, Fatigued or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?
☐	☐	**Observed?** Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?
☐	☐	**Pressure?** Do you have or are you being treated for **High Blood Pressure**?