Dr. Louis I. Freeman, DDS
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Dental History

Name ______________________________ Date ____/____/____
First Mi Last

How frequently do you see your dentist? 6 months ☐ Yearly ☐ Other ________ Last Dental Exam ________

Have you ever been given oral hygiene instructions in: Brushing ☐ Flossing ☐ Other ________

Have you ever had local anesthetic? ☐ Yes ☐ No

Any complications: ______________________________

Have you ever had complications after extractions? ☐ Yes ☐ No

Have you ever experienced prolonged bleeding following extractions in the past? ☐ Yes ☐ No

Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat Other ________

Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously

Do your gums feel swollen or tender? ☐ Yes ☐ No

Do you catch food between your teeth? ☐ Yes ☐ No

Are you aware of any loose teeth? ☐ Yes ☐ No

Have you ever had a full series of dental X-rays? ☐ Yes ☐ No

Does your jaw crack, pop or grate when you open widely? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Dental Update ______________________________

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PATIENT (GUARDIAN) CERTIFICATION AND APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

I, the undersigned , consent to the performing of dental and oral surgery procedures agreed upon to be necessary including the use of local anesthetic as indicated and I will assume responsibility for fees associated with these procedure.

Patient (Guardian Signature) ______________________________ Date ________________

Date	Medical Changes	Sign	Date	Medical Changes	Date