Have you ever experienced any of the following problems with your jaw?

Clicking/Clenching/Grinding	☐Yes	☐No
Pain in or around ears and/or headaches	☐Yes	☐No
Difficulty opening or closing	☐Yes	☐No
Difficulty chewing	☐Yes	☐No
Do you have history of trauma to your jaw	☐Yes	☐No
Have you ever been diagnosed with TMJ/TMD	☐Yes	☐No

Do you have any of the following problems?

Have you ever had prolonged bleeding following extractions?	☐Yes	☐No
Have you ever needed to see a Periodontist (Gum Specialist)?	☐Yes	☐No
Do you now have bleeding gums or any other gum conditions?	☐Yes	☐No
Are you having any pain or discomfort at this time?	☐Yes	☐No
Do you feel nervous about having dental treatment?	☐Yes	☐No
Is there anything you dislike about your smile?	☐Yes	☐No

Is there anything related to your medical and/or dental history that you have not indicated above?

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I certify that I have read and understood the above information, and that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information (including diagnosis and records of any treatment or examination rendered to me or my child) to third party payers and/or healthcare practitioners. I authorize and request my insurance company to directly reimburse the dentist or dental group any benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or on behalf of my dependents. I consent to photographs being taken. I understand they may be used for illustration and for documentation of my treatment.

______________________________X______________________________X________________

Name of Patient **Signature of Patient or Guardian** **Date**