Dental Health When was your last dental Visit? How offen do you brash files your teeth? What texture brush do you say? Soft Medium Hard Do your game feel tender or swollen? Or you separetine of your swollen? Or you separetine of the following problems with your year? Or you so you separetine of closing? Or tee Ono Do you go get sell?? Or you have ver experienced any of the following problems with your year? Clicking? Or tee Ono Do you clean or grind your teeth while sleeping or during the day? On you shard or grind your teeth while sleeping or during the day? On you shard or grind your teeth while sleeping or during the day? On you have frequent headaches? Or yes Ono Are you nervous about your treatment? Or the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patents) health. It is my experienced by to inform the dental office of any changes in nectical status. Signature of Patent, Parent or Guardian: X Date: X Date: Vies Ono Siring/ No Epinephrine Oves Ono No Diffee Notes Only Uses Carbocaine Over Ono No Epinephrine Oves Ono No Siring/ No S	Dental fleatin					
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Have you ever experienced any of the following problems with your jaw? Clicking? Yes No Difficulty opening or closing? Yes No Pain in Joint or side of face? Yes No Difficulty chewing Yes No Difficulty chewing Yes No Do you clench or grind your teeth while sleeping or during Do you have frequent headaches? Yes No Are you nervous about your treatment? Yes No If yes To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Signature of Patient, Parent or Guardian: X Date: Yes No No Numbing needs extra time Yes No No Numbing needs extra time Yes No Patient is on Blood Thinner Yes No Patient is on Blood Thinner Yes No CA channel blocker Yes No	Do you experience dry mouth?		○Yes ○No			
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Do you clench or grind your teeth while sleeping or during the day? Do you have frequent headaches?	Pain injoint or side of face?	○Yes () No			
the day? Do you have frequent headaches? Are you nervous about your treatment? Yes No If yes To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Signature of Patient, Parent or Guardian: X Date: Office Notes Only Uses Carbocaine String/ No Epinephrine Yes No Numbing needs extra time Yes No Uses N2O Patient is on Blood Thinner Yes No Patient is on Blood Thinner Yes No CA channel blocker Yes No	Difficulty chewing	○Yes ○) No			
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