River Ridge Dental

Dental History

What brings you to our office today? _____

Previous dental office _____ Date of last dental visit _____

Address _____ Phone _____

Circle if you have had problems with any of the following:

Bad Breath	Bleeding Gums	Sensitivity to cold
Sensitivity to hot	Periodontal treatment	Sores in mouth
Food collection between teeth	Grinding or clenching teeth	Sensitivity to sweets
Clicking or popping in jaw	Loose teeth or broken fillings	Sensitivity when biting

How often do you brush? _____ Floss? _____

How happy are you wih the appearance of your teeth?

Why did you leave your previous dentist? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

_____

How can we accommodate you better during your dental visit? _____

Here at River Ridge Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Traditional Orthodontics (Brackets)	Veneers/Lumineers	Invisalign
Sealants	Smile Makeover	Bonding
Partials/Dentures	Crown and Bridge	Implant Crowns
	Night/Sport Guards	

General Consent to Perform Dentistry

I hereby authorize any of the doctors at this facility and dental auxilliaries to proceed with and perform the dental procedures and treatments as have been explained to me. I understand that treatment can only be estimated and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Signature of patient, parent if minor _____ **Date** _____