First Nations Health Authority
Health through wellness

Dental History

Authorization for Dental Treatment

NAME: _____ DATE OF BIRTH (DD/MM/YYYY): _____/_____/_____

STATUS #: _____

1) Do you have any concerns with your teeth or mouth? **YES / NO**
If yes, please explain: _____

_____

2) Do you have any pain or clicking with your jaws? **YES / NO**

3) Please indicate how often you visit an oral health professional (dentist, dental therapist, dental hygienist):
☐ Once / year ☐ Twice / year ☐ Rarely ☐ Never

4) What was the reason for your last dental visit?_____
_

5) Who was your last dentist/dental therapist/hygienist? _____

6) When last did you have x-rays? (DD/MM/YYYY): _____/_____/_____

Can we contact them for copies of your X-rays? **YES / NO** _____

Dentist/Office Name: _____ Phone number: _____

Address: _____

7) Do you wear any appliances? (e.g. sports guard, nightguard, denture) **YES / NO**

8) How often do you replace your toothbrush? _____

9) Have you received orthodontic treatment to align your teeth? **YES / NO**

10) Have members of your immediate family had gum (periodontal) disease or tooth loss? **YES / NO**

I have provided responses to the above dental history questions to the best of my knowledge.

CLIENT FULL NAME (please print): _____

(If used) PROXY FULL NAME (please print): _____

If proxy, what is your relationship to client? _____

CLIENT/PROXY SIGNATURE: _____

DATE (DD/MM/YYYY):_____/_____/_____ CI: _____