

DENTAL HISTORY

Patient Name _____ Date _____

Date of last dental visit? _____ Last dental cleaning _____ Last Full Mouth X-rays _____

Previous Dentist's name _____

Address _____ State _____ Zip _____

Telephone _____

What are your chief concerns? List from most to least important.

1. _____
2. _____
3. _____
4. _____

How often do you have your dental examination? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Sonicare, Braun, Toothpick, Proxybrush, Hydrofloss, etc.) _____

Do you have active dental problems now? _____ Yes No _____

Gum disease? _____ Yes No _____

Bleeding gums? _____ Yes No _____

Decay? _____ Yes No _____

Broken Teeth? _____ Yes No _____

Do you have trouble with bad breath? _____ Yes No _____

Do you have any loose teeth? _____ Yes No _____

Where? _____

Have you ever had:

Orthodontics treatment? _____ Yes No _____

Oral surgery or teeth removed? _____ Yes No _____

Periodontal treatment? _____ Yes No _____

Endodontic treatment? _____ Yes No _____

Your teeth ground or the bite adjusted? _____ Yes No _____

General anesthesia? _____ Yes No _____

A broken jaw? _____ Yes No _____

Missing back teeth with no replacement? _____ Yes No _____

A bite plate, splint or mouth guard? _____ Yes No _____

If so, please describe cause _____

DENTAL HISTORY (Continued)

Patient Name _____ Date _____

Are any of your teeth sensitive to:

- Hot or cold?
- Biting or chewing
- Sweets?

Have you ever experienced:

- Cold sores, blisters, or any other oral lesions?
- Gum disease or tooth loss?
- Loose teeth or change in your bite?
- Mouth odors or bad tastes?
- Food getting caught between your teeth

Where? _____

Problems of prolonged bleeding either from a cut, or a dental procedure such as a cleaning?

_____ Yes No _____

Have you ever been involved in an accident or injury? (Includes: sports injury, serious slips or falls, skiing, etc.)?

_____ Yes No _____

When? _____

What happened? _____

APPEARANCE AND YOUR COMFORT

Are you satisfied with the appearance of your teeth? _____ Yes No _____

Do you think your teeth are affecting your general health? _____ Yes No _____

Do you feel nervous about having dental treatment? _____ Yes No _____

If so what is your biggest concern? _____

Have you ever had an upsetting dental experience? _____ Yes No _____

If yes, please describe _____
