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DENTAL HISTORY

PATIENT NAME ____ Birth Date ___________________

What was the date of your last dental exam?____________________ Date of last full mouth xrays _________________

How often have you received dental care in the past?____

What treatment was received?____

Name of Previous Dentist ____ Phone _______________________

May we request records? O yes O no

Please explain any current dental concerns ____

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Have you experience difficulties with past dental treatment? O yes O no If yes, please explain __________________

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Do you wear dentures? O no upper lower complete If so, how long? __________________________________

If so, is this your first set? O yes O no

Are your teeth sensitive to heat? O yes O no cold? O yes O no sweets? O yes O no

How often do you brush your teeth? ____

How often do you use dental floss? ____

Do your gums bleed when you brush or floss? O yes O no

Have you ever been instructed on the proper techniques for brushing and flossing? O yes O no

Have you had periodontal (gum) treatment? O yes O no When? ____

Are you aware of any lumps, swelling or sores in your mouth? O yes O no

Do you often have a bad taste in your mouth? O yes O no

Have you had orthodontic treatment (braces)? O yes O no

Do you have pain in your face, head or neck other than toothaches? O yes O no

Do you habitually clench or grind your teeth at night? O yes O no

Do you experience frequent earaches, popping or clicking when you chew? O yes O no

How do you feel about your dental health in general? ____

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____

How do you feel about saving your teeth? ____

____

Are you happy with the appearance of your teeth/smile? O yes O no

Are there other dental conditions of which we should be aware? ____

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To the best of my knowledge, the questions on this form have been accurately answered.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ___________________________________DATE ____________