DENTAL HISTORY

WELCOME! So that we may provide you with the best possible care please complete this dental history form.

ALL INFORMATION IS COMPLETELY CONFIDENTIAL

What is the reason for your visit today? _____

Date of last Dental Visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-rays: _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Tel. #: _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____

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

What other dental aids do you use? (Interplak, toothpick, etc.) _____

DO YOU HAVE ANY DENTAL PROBLEMS NOW? Yes: _____ No: _____

If yes please describe: _____

ARE ANY OF YOU TEETH SENSITIVE TO:

Hot or Cold? Yes___ No___
Sweets? Yes___ No___
Biting or Chewing? Yes___ No___
Have you noticed any mouth odors or bad tastes? Yes___ No___

Any other oral lesions? Yes___ No___

HAVE YOU EVER HAD:

Orthodontic treatment? Yes___ No___
Oral Surgery? Yes___ No___
Periodontal Treatment? Yes___ No___
Your teeth ground or your bite adjusted? Yes___ No___
A serious injury to Yes___ No___

If so, please describe, including cause:

_____

DO YOUR GUMS BLEED OR HURT? Yes___ No___

Have your parents experienced gum disease or tooth loss? Yes___ No___
Have you noticed any loose teeth or change in you bite? Yes___ No___

HAVE YOU EXPERIENCED:

Clicking or popping of the jaw? Yes___ No___
Pain in Joint, Ear, Side of Face? Yes___ No___
Difficulty in opening or closing the mouth? Yes___ No___
Headaches, neck aches, or shoulder aches? Yes___ No___