DENTAL HISTORY

What has prompted your visit to our office today? _____

Name of your previous dentist _____ City _____

When was your last visit to a dental office? _____ ; last cleaning? _____ ; last x-ray? _____

How often did you see your dentist? _____ Are you having any dental troubles right now? _____

Would you like to retain your healthy natural teeth as long as possible? _____

Do any of the following cause you discomfort? Hot _____ Clod _____ Sweet _____ Chewing _____

Have you had periodontal (gums) treatment? _____ Do you gums bleed? _____

Do your gums ever feel tender/swollen? _____ Do you have any loose teeth? _____

Are you aware of bad breath/taste in your mouth? _____ Do you smoke? _____

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____ Other _____

Do you clench or grind your teeth? _____ Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____ Are you teeth worn down? _____

Do you have frequent headaches _____ ; earaches? _____

Have you ever had orthodontic treatment (braches)? _____ If yes, when? _____

Do you have missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ ; Removable partial _____ ; Full denture _____ ; Dental implant _____

Are you happy with the replacement? _____ Please describe: _____

_____

How do you feel about the appearance of our smile? _____

What cosmetic dentistry have you had one? _____

Are you happy with it? _____ Please explain _____

_____

Have you ever been sedated for a dental appointment? _____

Have you ever had an unpleasant dental visit? _____ If yes, please comment _____

_____

Please add anything you feel is important _____

_____