

DENTAL HISTORY

Reason for today's visit _____

Date of last dental care _____ Date of last dental X-rays _____

Previous Dentist _____

Address _____

Have you ever been told that you require an antibiotic prior to any medical or dental procedures? Yes No

Are you allergic to the latex in gloves? Yes No

Do you have frequent head, neck, or back pain? Yes No

Do you normally get fever blisters/cold sores? Yes No

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

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

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____