

NAME _____

DENTAL HISTORY

1. Have you noticed any of the following?
 - Grinding or clenching teeth..... yes no
 - Teeth tender when chewing..... yes no
 - Bleeding gums when brushing..... yes no
 - Food catching between teeth..... yes no
 - Teeth sensitive to hot, cold, or sweets..... yes no
 - Swelling or sores in mouth..... yes no
 - Pain in teeth or jaws..... yes no
2. Have you ever had your teeth straightened?..... yes no
3. Have you had any serious trouble associated with previous dental care?..... yes no
If yes, please explain_____
4. Have you been satisfied with your previous dental care?.. yes no
If no, please explain_____ yes no
5. Are you satisfied with the appearance of your teeth?..... yes no
If no, please explain..... yes no
6. Would you like to keep your natural teeth?..... yes no
7. Have you ever been treated for periodontal disease?..... yes no
8. How often do you brush your teeth?_____
9. How often do you floss your teeth?_____
10. Approximate date of last dental treatment_____
11. Approximate date of last cleaning_____
12. Do you have any concerns you would like evaluated today?yes no
If yes, please explain_____
13. Previous dentist_____
14. Who can we thank for referring you to our office?_____
15. Family physician's name and phone number_____