OAKSIDE DENTAL
STEVEN J. HORN D.D.S.

Dental History

Name:_____

HOW LONG SINCE you have seen a Dentist?_____

Date of Last COMPLETE Dental Exam, Date:_____

Date of last FULL MOUTH X-RAYS, Date: _____

YES NO

___ ___ Are you having problems now? If so, what?_____

___ ___ Do you wear (Partials or Full) DENTURES? If so are you UNHAPPY with your dentures?_____

___ ___ Would you like to know more about PERMANENT REPLACEMENTS?

___ ___ Are you APPREHENSIVE about dental treatment?

___ ___ Have you had any PERIODONTAL (GUM) treatment?

___ ___ Do your gums BLEED, or feel TENDER or IRRITATED?

___ ___ Are you aware of GRINDING OR CLENCHING YOUR TEETH?

___ ___ Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)

___ ___ Do you have HEADACHES, EARACHES, or NECK PAIN?

___ ___ Have you worn BRACES on your teeth? (ORTHODONTICS)

___ ___ Do you have DISCOLORED teeth that bother you?

___ ___ Would you like your smile to LOOK BETTER or DIFFERENT?

___ ___ Do you REGULARLY use DENTAL FLOSS?

How would you rate your dental health? (circle) GOOD FAIR POOR

How do you feel about your teeth?_____

Name of Previous Dentist?_____ City_____State_____

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment. (#1 being of most concern)

Fear of Pain _____ Cost of treatment_____ Lack of concern_____ MISSING work time_____

Who May We Thank for Referring You to Our Office_____