



PATIENT DENTAL HISTORY

Patient Name _____

- 1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquid/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquid/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you experienced any of the following problems in your jaw?
a) Clicking? Yes No
b) Pain (joint, ear, side of face)? Yes No
c) Difficulty in opening or closing? Yes No
d) Difficulty in chewing? Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you had any orthodontic work? Yes No
13. Have you ever had prolonged bleeding following extractions? Yes No
14. Have you ever had instruction on the correct method of brushing your teeth? Yes No
15. Have you ever had instructions on the care of your gums? Yes No
16. Have you ever had periodontal treatment or has it been recommended to you in the past? Yes No
17. Do you want your treatment done while sedated? Yes No

What is the reason for your visit today? _____

Date of last dental visit _____

What was done at your last dental visit? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are you satisfied with your teeth's appearance? Yes No

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X

PATIENT, PARENT, OR GUARDIAN

DATE