DENTAL HISTORY

NAME_____ AGE _____

PREVIOUS DENTIST _____

DATE OF LAST EXAM_____ DATE OF LAST X-RAYS_____

REASON FOR TODAY'S VISIT _____

_____

HOW OFTEN DO YOU BRUSH?_____

HOW OFTEN DO YOU FLOSS? _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

__ BAD BREATH
__ BLEEDING GUMS
__ CLICKING OR POPPING OF JAW
__ FOOD COLLECTION BETWEEN TEETH
__ GRINDING TEETH
__ LOOSE TEETH OR BROKEN FILLINGS

__ PERIODONTAL TREATMENT
__ SENSITIVITY TO COLD
__ SENSITIVITY TO HOT
__ SENSITIVITY TO SWEETS
__ SENSITIVITY WHEN BITING
__ ORTHODONTIC TREATMENT

__ LOST OR MISSING TEETH
__ SERIOUS INJURY TO THE MOUTH OR HEAD

__ SMOKE OR CHEW TOBACCO

DO YOU HAVE ANY DENTAL CONCERNS THAT YOU WOULD LIKE US TO KNOW? __YES __NO

IF YES, PLEASE DESCRIBE_____

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