Dental History

Patient name ___________________________________ Date______________________

Date of last dental visit _______ Last dental cleaning ________ Last Full Mouth Xrays __________

Previous Dentist Name _____________________________ Telephone______________________

Address ____

How often do you have a dental exam? _____________________

How often do you brush? ____________ Floss? ____________

Do you active dental problems now? ___Yes No___

Gum disease? c Yes c No Bleeding gums? c Yes c No

Decay? c Yes c No Broken teeth? c Yes c No

Do you trouble with bad breath? c Yes c No

Do you have any loose teeth? c Yes c No Where?_________________________

Do you get food caught between teeth often? c Yes c No Where? __________________

Have you ever had:

Orthodontic treatment c Yes c No Your teeth ground or bite adjusted c Yes c No

Periodontal treatment c Yes c No General anaesthesia c Yes c No

Endodontic treatment c Yes c No A broken jaw c Yes c No

Injections in your TM Joint c Yes c No A bite appliance c Yes c No

Oral surgery or teeth removed c Yes c No

When and by whom ____

Do you:

Clench or grind your teeth c AM c PM Chew gum c Yes c No

Experience headaches c Yes c No Bite pencils/pens c Yes c No

Teeth hit in front first c Yes c No Cheek biting c Yes c No

Nail biting c Yes c No Experience cold sores c Yes c No

Other habits: ____

Are your teeth sensitive to:

Hot: c Yes c No Cold: c Yes c No

Sweet: c Yes c No Soreness biting: c Yes c No

Have you experienced prolonged bleeding? c Yes c No

When, describe ____

Have you had an accident, experienced trauma? c Yes c No

Describe incident, date & symptoms... ____

____

Do you snore or have sleep apnea (stop breathing)? c Yes c No

Are you comfortable with dental treatment? c Yes c No

Do you have cosmetic or general dental concerns/requests? c Yes c No _

Describe____

____