DENTAL HISTORY

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient's name: _____

Please state briefly the reason for your visit: _____

_____

Last dental visit: _____

	YES	NO
Have you had X-Rays taken?	___	___
Do your gums feel tender or irritated?	___	___
Do your gums bleed while brushing or flossing?	___	___
Are your teeth sensitive to hot or cold to liquids/food?	___	___
Are your teeth sensitive to sweet or sour?	___	___
Do you feel pain to any of your teeth?	___	___
Are any teeth loose or missing?	___	___
Have you experienced any of the following problems in your jaw?	___	___
Clicking?	___	___
Pain (Joint, Ear, Side of your face)?	___	___
Difficulty in opening or closing?	___	___
Difficulty in chewing?	___	___
Do you have frequent headaches?	___	___
Do you clench or grind your teeth?	___	___
Have you ever had any teeth extracted?	___	___
If yes 1. Any bleeding problems? _____		
2. Have they been replaced? _____		
Do you have any sores or lumps in or near your mouth?	___	___
Have you had any head, neck, or jaw injuries?	___	___
How often do you floss?	_____	
How many times a day do you brush?	_____	
Does food trap between your teeth?	___	___

DATE: _____ Patient/Guardian Signature: _____