Dental History:

Have you ever been seen by a dentist before? ( ) Yes ( ) No

If yes, Date of last visit? _____

Reason for last visit? ( ) Routine Exam, Cleaning, etc

( ) Restorative work (fillings, crowns, etc)

( ) Toothache

Last Date of the following x-rays? Bitewings: _____

Full Mouth Series or PAN: _____

***Did you have your most recent x-rays sent to us? ( ) Yes ( ) No**

Reason for today's visit in our office:

( ) Establish care: exam, cleaning, and any applicable xrays

( ) Problem focused exam/Toothache/Broken Tooth

Please explain: _____

Have you ever had any problems associated with dental work? ( ) Yes ( ) No

If yes, please explain: _____

Have you ever had any problems with or reactions to any dental anesthetics? ( ) Yes ( ) No

If yes, which anesthetic? _____

Describe your reaction:

Heart Palpitations ( ) Sweating ( ) Difficulty Breathing ( )

Rash or Hives ( ) Prolonged anesthesia ( )

Difficulty achieving complete anesthesia? ( ) Other ( ) _____

Dental History Continued……

How often do you brush? _____/Day

How often do you floss? Daily ( ): How often? _____

Weekly ( ): How often? _____

Occasionally ( ): How often? _____

Never ( )

Please select all of the following topics you would like to discuss:

( ) Whiter Teeth ( ) Fresh Breath ( ) Straighten Teeth (Orthodontics)

( ) Close spaces/gaps ( ) Repair/replace existing work

( ) Other: _____

Are you aware of grinding or clinching your teeth?

( ) Yes: How often? _____

During which time period: ( ) Day ( ) Night

Do you wear an occlusal guard/night guard? ( ) Yes ( ) No

( ) No

Any additional dental information you wish to share? _____

_____

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