

Patient Dental History

Former Dentist _____ Phone _____

City _____ State _____ Date of last exam/x-rays _____

What is the primary reason for your visit today?

Please check all that apply:

- | | |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Do your gums bleed while brushing or flossing? | <input type="checkbox"/> Do you clench or grind your teeth? |
| <input type="checkbox"/> Are your teeth sensitive to hot or cold? | <input type="checkbox"/> Do you wear dentures or partials? |
| <input type="checkbox"/> Are your teeth sensitive to biting pressure? | If yes, date of placement _____ |
| <input type="checkbox"/> Do you feel pain in any of your teeth? | <input type="checkbox"/> Are you apprehensive about dental visits? |
| <input type="checkbox"/> Do you have any mouth sores or lumps? | <input type="checkbox"/> Would you like gas or medication to help you relax during appointments? |
| <input type="checkbox"/> Do you have frequent headaches? | |

Have you ever experienced any of the following problems in your jaw?

- Clicking Pain (joint, ear, side of face) Difficulty in opening or closing
- Difficulty chewing Do you chew on one side of your mouth? Right/ Left (Circle one)

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What would you rate your smile on a scale of 1-10 (10 being best)? _____

Are you aware of a dental problem that needs treatment? _____

Have you had dental treatments recommended that were not done? _____

How important is it for you to keep your teeth for a lifetime? _____

Does the appearance of your teeth keep you from laughing or smiling? _____

If you could change anything about your smile, what would it be? _____

Have you ever been treated for periodontal disease(gum disease)? _____

If so, when? _____

Have you ever had excessive bleeding following an extraction, or dental procedure? _____

If so, when? _____

Have you ever had trouble /issues due to dental treatment?
