DENTAL HISTORY

NAME ____________________ DATE OF BIRTH ____________________ ACCT # ______________

DATE OF LAST DENTAL VISIT? ______________ PREVIOUS DENTIST NAME: ____________________

PREVIOUS DENTIST ADDRESS: ______________________________ PHONE: ______________

DATE OF LAST COMPLETE EXAM ____________ DENTAL CLEANING ____________________

HAVE YOU HAD REGULAR DENTAL VISITS? Y N

LAST DENTAL X-RAYS TAKEN? DATE__________ FULL MOUTH__________ BITEWINGS__________

ARE YOU HAVING PROBLEMS NOW? Y N SPECIFY ______________________________

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HAVE YOU LOST ANY TEETH OR HAVE ANY TEETH BEEN REMOVED? Y N

HAVE ANY OF YOUR TEETH BEEN REPLACED? Y N

HAVE YOU HAD ANY TRAUMA TO YOUR FACE OR TEETH? Y N

HOW HAVE YOUR TEETH BEEN REPLACED?

FIXED BRIDGE	DATE ____________
REMOVABLE (PARTIAL)	DATE ____________
DENTURE	DATE ____________
IMPLANTS	DATE ____________

ARE YOU SATISFIED WITH THE REPLACEMENTS? Y N

WOULD YOU LIKE MORE INFORMATION REGARDING PERMANENT REPLACEMENTS (IMPLANTS)? Y N

HAVE YOU EVER HAD ANY PROBLEMS/COMPLICATIONS WITH PREVIOUS DENTAL TREATMENT? ____________

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ARE YOU ANXIOUS ABOUT RECEIVING ANY DENTAL TREATMENT? Y N

ARE YOU ANXIOUS ABOUT RECEIVING ANESTHETIC? Y N

HAVE YOU WORN BRACES? Y N

DO YOU HAVE ANY OF THE FOLLOWING:

FREQUENT HEADACHES	Y N	PAIN, SORENESS IN FACIAL MUSCLES	Y N
FREQUENT NECKACHES	Y N	LIMITED MOUTH OPENING	Y N
DIZZINESS, LIGHT HEADNESS	Y N	PAIN IN SHOULDERS	Y N
EARACHES, RINGING IN EARS	Y N	PAIN, STIFFNESS IN BACK	Y N
JAWS CLICKING OR POPPING	Y N	NUMBNESS IN ARMS, FINGERS	Y N

ARE YOUR TEETH SENSITIVE TO:(circle) HOT COLD SWEETS PRESSURE

DO YOU BRUSH REGULARLY? Y N

DO YOU FLOSS REGULARLY? Y N

DO YOUR GUMS BLEED WHEN BRUSHING? Y N

DO YOUR GUMS FEEL TENDER OR IRRITATED? Y N

HAVE YOU HAD GUM SURGERY? Y N

WHEN ______________________________

WHERE/WITH WHOM ____________________

WHAT TYPE OF SURGERY ________________

ARE YOUR TEETH LOOSE, TIPPED SHIFTED OR CHIPPED? Y N

DO YOU HAVE DISCOLORED TEETH THAT BOTHER YOU? Y N

WOULD YOU LIKE YOUR SMILE TO LOOK BETTER OR DIFFERENT? Y N

ARE THERE ANY DENTAL CONCERNS YOU WOULD LIKE US TO ADDRESS SPECIFICALLY? ______________

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IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD IT BE? ____________________

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