PATIENT DENTAL HISTORY

PATIENTS NAME: _____
FIRST MIDDLE LAST

D.O.B: _____ PREVIOUS DENTIST NAME: _____ PHONE #: _____

DATE OF LAST DENTAL EXAM AND CLEANING: _____ DATE OF LAST FULL MOUTH X-RAYS: _____

PLEASE CHECK EACH BOX BELOW TO INDICATE ANY OF THE FOLLOWING CONCERNS THAT APPLY TO YOU:

( ) AMALGAMS TO BE REPLACED WITH COMPOSITES
( ) BAD BREATH
( ) BLEEDING GUMS
( ) BLISTERS/SORES/BUMPS IN OR AROUND
( ) BRIDGE ( ) UPPER ( ) LOWER
( ) BROKEN/CHIPPED TOOTH
( ) BROKEN FILLINGS
( ) CLENCHING/GRINDING
( ) COMPLICATIONS FROM EXTRACTIONS
( ) CONCERNS WITH THE APPEARANCE OF YOUR TEETH
( ) DO YOU WEAR AN OCCLUSAL GUARD? ( ) YES ( ) NO
( ) DENTURES ( ) UPPER PARTIAL ( ) LOWER PARTIAL
( ) DENTURES ( ) UPPER COMPLETE ( ) COMPLETE LOWER
( ) DISCOMFORT/ CLICKING OR POPPING OF THE JAW
( ) DRY MOUTH
( ) EXTRACTIONS ( ) WISDOM ( ) OTHER
( ) FOOD IMPACTION
( ) IMPLANTS
( ) IMPLANTS
( ) LOCKING JAW
( ) MOUTH BREATHER WHILE SLEEPING
( ) ORTHODONTIC TREATMENT
( ) ORAL SURGERY
( ) PAIN IN OR AROUND EAR
( ) PERIODONTAL TREATMENT
( ) RED OR SWOLLEN GUMS
( ) RINGING IN THE EARS
( ) SENSITIVE TO HOT/COLD/SWEETS
( ) SENSITIVE TOOTH/TEETH OR GUMS
( ) STAINED TEETH
( ) UNPLEASANT TASTE
( ) UNUSUAL SOUNDS IN THE EAR(S) WHEN CHEWING
( ) UNPLEASANT DENTAL EXPERIENCE, PLEASE EXPLAIN
_____
_____
_____

HOW MANY TIMES PER DAY DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____
HOW OFTEN DO YOU USE A MOUTH RINSE? _____ WHAT TYPE OF RINSE DO YOU USE? _____
WHAT TYPE OF TOOTH BRISTLE DO YOU USE? ( ) SOFT ( ) MEDIUM ( ) HARD

WOULD YOU BE INTERESTED CHANGING YOU SMILE WITH LAMINATES/VENEERS? ( ) YES ( ) NO
WOULD YOU LIKE TO BRIGHTEN YOUR SMILE WITH BLEACHING? ( ) YES ( ) NO
WOULD YOU LIKE TO DISCUSS INVISILIGN (STRAIGHTEN TEETH)? ( ) YES ( ) NO

SIGNATURE: _____ DATE: _____

DOCTORS NOTES