DENTAL HISTORY

IS THIS YOUR FIRST VISIT TO THIS OFFICE? ……..… YES NO

DO YOU HAVE DENTAL EXAMINATIONS ON A REGULAR BASIS? YES NO

APPROXIMATE DATE OF LAST EXAM: _____

FORMER DENTIST _____

_____

DO YOU BRUSH YOUR TEETH ON A REGULAR BASIS? …… YES NO

DO YOU USE DENTAL FLOSS ON A REGULAR BASIS? …… YES NO

IS KEEPING ALL YOUR TEETH IMPORTANT TO YOU? …….. YES NO

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ….. YES NO

ARE YOU HAVING ANY PAIN OR DISCOMFORT IN YOUR TEETH? YES NO
GUMS? YES NO
JAW? YES NO
FACE? YES NO

DO YOU CLENCH OR GRIND YOUR TEETH? …….. YES NO

DO YOU HAVE BAD BREATH OR BAD TASTES IN YOUR MOUTH? YES NO

DO YOU USE TOBACCO PRODUCTS? …… YES NO

HAVE YOU HAD PERIODONTAL (GUM DISEASE) TREATMENT? … YES NO

HAVE YOU HAD ORTHODONTIC (BRACES) TREATMENT? …….. YES NO

HAVE YOU EVER HAD PROBLEMS WITH DENTAL TREATMENT? .. YES NO

IF YES, PLEASE EXPLAIN _____

_____

PLEASE LIST ANY CONCERNS YOU HAVE REGARDING YOUR DENTAL HEALTH:

_____

_____

_____

I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care.

(Signature) _____