DENTAL HISTORY

Please check if you have ever had any of the following:

- ○ Sensitivity to cold
- ○ Sensitivity to hot
- ○ Sensitivity when biting (or to pressure)
- ○ Sensitivity to sweets
- ○ Fingernail or cheek biting
- ○ Frequent blisters on lips or mouth
- ○ Jaw/ear pain
- ○ Grinding/clenching teeth
- ○ Clicking or popping jaw
- ○ Worn/chipped teeth
- ○ Mouth breathing
- ○ Use a Water-Pik
- ○ Bleeding gums
- ○ Periodontal treatment
- ○ Loose teeth/broken fillings
- ○ Dark teeth
- ○ Orthodontic treatment. Year: ________
- ○ Fluoridated water/Well water
- ○ Food sticks between teeth
- ○ Mouth sores/growths
- ○ Bad breath/taste
- ○ Hard to floss
- ○ Complications from extractions

How often do you brush? ______________________________

What texture? ○ Soft ○ Medium ○ Hard

What type of tooth brush? ○ Electric ○ Regular

Mouthrinse brand: ______________________________

Fluoride rinse/gel brand: ______________________________

Toothpaste brand: ______________________________

Toothbrush brand: ______________________________

Any other homecare devices you use for your dental care? ______________

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How often do you floss? ______________________________

Is it difficult to brush or floss any areas of your mouth? ○ Yes ○ No
If yes, please explain ______________________________

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Do you use tobacco (cigarettes or smokeless)? ○ Yes ○ No If yes, how often?______________________________

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Do your gums bleed when brushing or flossing? ○ Yes ○ No

Do you have dry mouth? ○ Yes ○ No

Do you snack between means on sweets, gum or soda pop? ○ Yes ○ No

Do you chew on both sides of your mouth? ○ Yes ○ No

Have you been instructed in caring for the health or your gums? ○ Yes ○ No

Have you ever been treated for periodontal disease? ○ Yes ○ No
If yes, when? ______________________________

Where? ______________________________

How was the infection treated? ______________________________

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Are you anxious about receiving dental treatment? ○ Yes ○ No If yes, what do you dislike about it? ______________________________

____

Has fear of discomfort kept you from regular dental visits in the past? ○ Yes ○ No

Have you ever had a reaction to a dental product or procedure? ○ Yes ○ No If yes, please explain ______________________________

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How do you feel about the appearance of your teeth? ______________

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Do you like the way your smile looks? ○ Yes ○ No If no, what dissatisfies you? ______________________________

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Are you teeth white enough? ○ Yes ○ No

Are there fillings or dental work that looks bad to you? ○ Yes ○ No

Are your teeth straight enough? ○ Yes ○ No

Do you have spaces between your teeth that you don't like? ○ Yes ○ No

Has cost prevented you from enhancing your smile in the past? ○ Yes ○ No

Previous Dentist: ______________________________

Date of Last visit: ______________________________

Date of last Full-Mouth X-ray: ______________________________

Date of last Bitewing X-ray: ______________________________

Do you have any concerns about getting your mouth in excellent health?
○ Yes ○ No If yes, what concerns you? ______________________

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the information inquired above, have been answered in satisfaction. I will no hold my dentist, registered dental hygienist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. If my health history or medicine changes.

SIGNATURE: ______________________________ DATE: ______________________