DENTAL HISTORY

Comments

1. Purpose of initial visit

   _____

2. How long since your last dental visit?

   _____

3. What was done at that time?

   _____

4. Previous Dentist's name

   _____

5. When was the last time your teeth were cleaned?

   _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" IN THE COMMENTS SECTION.

6. Are you aware of a problem? YES NO
7. Have you made regular visits to a dental office? YES NO
8. Were dental x-rays taken? YES NO
9. Are you missing any teeth? YES NO
10. Would you like to know about permanent replacements? YES NO
11. Have you ever had any problems or complications with previous dental treatment? If yes, explain: YES NO

_____

12. Do you clench or grind your teeth? YES NO
13. Does your jaw click or pop? YES NO
14. Have you experienced any pain or soreness in the muscles around your face or ears? YES NO
15. Do you have frequent headaches, neck aches or shoulder aches? YES NO
16. Does food get caught in your teeth? YES NO
17. Are any of your teeth sensitive to HOT, COLD, SWEETS or PRESSURE? YES NO
18. Do your gums bleed or hurt? YES NO

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19. How often do you brush your teeth? _____
20. How often do you floss? _____

21. Are you happy with your smile?	YES	NO
22. Do you feel your breath is offensive at times?	YES	NO
23. Have you ever had gum treatment or surgery?	YES	NO
24. Are you aware of tonsil stones?	YES	NO
25. Do you any questions or concerns?	YES	NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PANTIENT'S/ GUARDIAN'S SIGNATURE

_____

DATE_____

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