

**PATIENT DENTAL HISTORY**

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN, WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT/COLD, SWEET/SOUR FOODS OR LIQUIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY OPENING/CLOSING.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION:** I CERTIFY THAT THE ANSWERS GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_