DENTAL IMAGE

DENTAL INFORMATION

What is the reason for your visit today? _____

_____

Date of your last dental visit?_____Last cleaning?_____Last Full Mouth x-rays?_____

What was done at your last dental visit?_____

_____

Previous Dentist's name_____

How often do you have dental visits?_____

How often do you brush your teeth?_____How often do you floss?_____

Have you ever used or are you currently using a topical fluoride?_____

Do you have any dental problems or pain now?_____

_____

DENTAL HEALTH HISTORY

Are your teeth sensitive to the following?

Hot or Cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Do you have bad taste or mouth odors? Yes No
Do you frequently get cold sores, blisters or other mouth lesions? Yes No
Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to get caught in between your teeth? Yes No
If yes, where?_____

Do you:
Clench or grind your teeth? Yes No
Bite your lips or cheeks regularly? Yes No
Have tired jaws, especially in the morning? Yes No
Mouth Breath while asleep or awake? Yes No
Snore or have sleep disorders? Yes No
Smoke or Chew tobacco? Yes No
If yes how much?_____

Have you ever been told to Pre-Medicate Prior to dental treatment? Yes No

Have you ever had:

- ❑ Orthodontic Treatment?
- ❑ Oral Surgery?
- ❑ Periodontal Treatment?
- ❑ Your teeth ground or bite adjusted?
- ❑ A bite plate or mouth guard?
- ❑ A serious mouth or head injury?

If so please describe_____

_____

Have you experienced any of the following?

- ❑ Clicking or popping of the jaw?
- ❑ Pain ?(joint, ear, side of face)
- ❑ Difficulty in opening/closing mouth?
- ❑ Difficulty in chewing?
- ❑ Headaches, neckaches, shoulder aches?
- ❑ Sore Muscles? (neck, shoulders)

Are you satisfied with your teeth's appearance? Yes No

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?_____

_____

Is there anything else about having dental treatment that you would like us to know?_____

_____

_____

Signature of patient (or parent)_____Date_____