Dental History

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general dentistry

NAME_____ **DATE OF BIRTH**_____

DATE OF LAST DENTAL CLEANING & EXAMINATION?_____**X-RAYS**_____

WHY HAVE YOU COME TO THE DENTIST TODAY?_____

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT?.....Y N

IF YES, FOR WHAT?_____

ARE YOU CURRENTLY IN PAIN?.....Y N

HAVE YOU EVER HAD A SERIOUS / DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?.....Y N

HAVE YOU EVER HAD GUM TREATMENT?.....Y N

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT (TMJ / TMD)?.....Y N

HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH IS: GOOD FAIR POOR

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?.....Y N

EXPLAIN_____

DO YOUR GUMS BLEED?.....Y N

HOW MANY TIMES A WEEK DO YOU FLOSS?_____ **HOW MANY TIMES A DAY DO YOU BRUSH?**_____

TYPE OF BRISTLES? SOFT MEDIUM HARD

HOW LONG DO YOU USE A TOOTHBRUSH BEFORE REPLACING IT?_____

ARE YOUR TEETH SENSITIVE TO HEAT, COLD, OR ANYTHING ELSE?_____

HAVE YOU LOST ANY TEETH? YES NO **IF YES, WHY?**_____

ADDITIONAL COMMENTS:_____

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SIGNATURE ***DATE***