

Patient Dental History

Patient Name _____ Guarantor _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1.) Do you have gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.) Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.) Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.) Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.) Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.) Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.) Have you ever experienced any of the following problems in your jaw? | | |
| a.) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> |
| b.) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c.) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> |
| d.) Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.) Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.) Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10.) Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.) Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.) Have you had any orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.) Have you ever had prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.) Have you ever had instructions on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.) Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |

What is the reason for your visit today? _____

Date of last dental visit? _____ What was done for you at that visit? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

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

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

Do you have any problems sleeping or been told you have Sleep Apnea? Yes No

If yes, please explain: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____

Patient, Parent or Guardian