JOYFUL DENTAL CARE
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DENTAL HISTORY

NAME:_____ DATE:_____

What is the reason for your visit today? _____

Date of last...

Dental visit? _____ Dental cleaning? _____ Full mouth x-rays? _____

What was done at your last dental visit?

_____

Previous Dentist

Name: _____ Phone number: _____

Address: _____

How often do you have dental exams? _____

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

Do you use any other dental aids (Ex: electric toothbrush, toothpick, etc)? _____

Do you have any dental problems at this time? ___ Yes ___ No

If yes, please describe: _____

_____

MARK ANY OF THE FOLLOWING YOU HAVE NOW OR HAVE HAD IN THE PAST

Sensitivity: ___Hot ___Cold ___Sweets ___Biting or chewing ___Pressure

Do you:

___ Clench or grind (awake or asleep)
___ Bite lips or cheeks
___ Mouth breather (awake or asleep)
___ Tired jaws, especially in morning
___ Jaw pop or click
___ Smoke or chew tobacco
___ Get cold sores, blisters or other lesions
___ Notice any loose teeth, change in bite, tipped or shifted teeth
___ Notice any mouth odors or bad tastes
___ Notice your gums bleed or hurt
___ Notice food getting caught between teeth. If yes, where: _____

Have your parents experienced gum disease or tooth loss? _____

Have you ever had:

___ Orthodontic treatment?
___ Oral Surgery?
___ Periodontal treatment?
___ Your teeth ground or bite adjusted?
___ A bite plate or mouth guard?
___ A serious injury to the mouth or head?
If yes, please describe: _____

Do you like your smile? ___ Yes ___ No

If no, please explain: