DENTAL HISTORY

CLIEN'T NAME _____ REFERRED BY _____

PREVIOUS DENTIST _____ HOW LONG _____

LAST DENTAL EXAM _____ LAST DENTAL X-RAY _____

LAST DENTAL TREATMENT _____

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 yr of longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____ _____

1. ARE YOU PRESENTLY HAVEING ANY DISCOMFORT OR CONCERNS ABOUT YOUR MOUTH REGARDING:

✹ cold	✹ hot	✹ sweet	✹ pressure	✹ cheek bites
✹ unpleasant breath	✹ chewing	✹ swelling	✹ bleeding	✹ tongue bites
✹ canker sores	✹ unpleasant taste	✹ food traps	✹ floss catches	✹ cold sores

ARE YOU EXPERIENCING:

✹ clenching	✹ muscle soreness	✹ headaches	✹ neck or shoulder pain
✹ grinding	✹ joint problems	✹ difficulty opening	✹ mouth breathing, asleep / awake

2. WHEN YOU HAVE ATTENDED OTHER DENTAL OFFICES IN THE PAST, WHAT HAS ACTUALLY HAPPENED?

✹ regular appt's	✹ teeth checked	✹ fillings	✹ x-rays	✹ orthodontics
✹ infrequent visits	✹ gums checked	✹ crown & bridge	✹ dentures	✹ home care inst.
	✹ cleaning	✹ ext's surgery	✹ fluoride	✹ root canal

✹ DENTIST

✹ HYGIENIST

HOW DID YOU FEEL ABOUT WHAT WAS DONE? _____

ANY CONCERNS (ANXIETIES, PHOBIAS, ETC.) REGARDING DENTAL TREATMENT? _____

3. TELL ME ABOUT YOUR PARENTS' DENTISTRY: _____

4. IS IT IMPORTANT TO KEEP YOUR TEETH? _____

5. ARE SILVER MERCURY FILLINGS A CONCERN FOR YOU? _____

6. ARE YOU SATISFIED WITH THE FUNCTION OF YOUR TEETH? _____

7. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? _____

8. HAVE YOU EVER HAD AN UPSETTING EXPERIENCE AT THE DENTAL OFFICE? _____

9. HAVE YOU EVER HAD TOOTH BRUSHING INSTRUCTION? ✹ yes ✹ no

10. HAVE YOU EVER HAD FLOSSING INSTRUCTION? ✹ yes ✹ no