Time 9:20 AM | S. Rangrass D.D.S., P.C. | Date 8/3/2016

DENTAL HISTORY

Patient Name: | Birth Date: | Date Created:

DENTAL HISTORY

What is the reason for your visit?		Comment	
Date of Last dental visit:			
Date of last dental cleaning:			
Date of last full mouth xray:			
What was done at your last dental visit?		Comment	
Previous Dentist Name		Comment	
Address		Comment	
Phone number		Comment	
How often do you have dental examinations?			
How often do you brush?			
How often do you floss?			
What other dental aids do you use? (toothpick, waterpick, etc.)		Comment	
Do you have any dental problems now?	○ Yes ○ No	If yes	
Do you have city or well water?			

DO YOU:

Clench or grind your teeth	○ Yes ○ No	Bite your lips or cheeks regularly	○ Yes ○ No	Chew your fingernails	○ Yes ○ No
Mouth breath	○ Yes ○ No	Snore	○ Yes ○ No	Smoke/Chew tobacco	○ Yes ○ No
Have any sleeping disorder	○ Yes ○ No				

Hold foreign objects with your teeth (pencils, pins, nails, pipe)	○ Yes ○ No	If yes	
Have tired jaws, especially in the morning	☐	If yes	

Have you experienced:

Clicking or Popping of the jaw	○ Yes ○ No	Pain in joint, ear or side of face	○ Yes ○ No	Difficulty in chewing	○ Yes ○ No
Headaches, neck ache, shoulder aches	○ Yes ○ No	Sore muscles(neck or Shoulder)	○ Yes ○ No	Odor or bad taste	○ Yes ○ No
Frequent cold sores	○ Yes ○ No	Frequent blisters or oral lesions	○ Yes ○ No		

Are your teeth sensitive to:

Hot or Cold	○ Yes ○ No	Sweets	○ Yes ○ No	Biting or chewing	○ 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 you bite?	○ Yes ○ No		
Does food tend to become caught in between your teeth?	○ Yes ○ No		
If yes, where	○ Yes ○ No	If yes	

Have you ever had:

Orthodontic treatment(braces)	○ Yes ○ No	If yes do you wear a retainer	○ Yes ○ No	Oral surgery	○ Yes ○ No
Periodontal treatment	○ Yes ○ No	Your bite adjusted	○ Yes ○ No	A bite Plate or mouth guard	○ Yes ○ No

Are you satisfied with the appearance of your teeth?	○ Yes ○ No		
Would you like to keep all your teeth all your life?	○ Yes ○ No		
Do you feel nervous about having dental treatment?	○ Yes ○ No		
If yes, what is your biggest concern	☐	If yes	
Have you had any serous injury to mouth or head?	○ Yes ○ No	If yes	
Is there anything else about having dental treatment that you would like us to know?	○ Yes ○ No	If yes	

CLINICAL NOTES ONLY