DENTAL HISTORY

Patient Name: Birth Date: Date Created:

What is the reason for your visit? Date of last dental visit: Date of last dental visit: Date of last dental denning: Uffact mouth visity: What was done at your last dental visit? Comment Do ace of last full mouth visity: What was done at your last dental visit? Comment Comment Comment How offen do you have dental examinations? How offen do you brush? Do you have only dental problems now? Ob you have only our teeth Yes No Shore Yes No If yes How the did foreign objects with your teeth (pennols, pins, nals, pipe) Yes No Head for your, you have dental visit when teeth (pennols, pins, nals, pipe) Yes No Have the given, especially in the morning If yes Have you experienced: Comment Yes No Pain it jont, ear or side of face Sore musdeficek or Shoulder) Frequent old sores Yes No Difficulty in chewing Yes No Odor or bod taste Yes No Are your teeth sensitive to: Yes No Frequent bleters or oral lesions Yes No Have you onticed any loose teeth or change in you bite? Yes No Pain it jont, ear or side of face Sore musdeficek or Shoulder) Frequent cold sores Yes No Shores Yes No Shores Yes No Shores Yes No Odor or bod taste Yes No Have you noticed any loose teeth or change in you bite? Yes No Provisional surgery Yes No Provisional surgery Yes No Provisional dealed or how you have and retainer Yes No Provisional surgery Yes No A bite Plate or mouth guard Yes No Provisional surgery Yes No Provi	DENTAL HISTORY					
Date of Last dental visit: Date of last dental cleaning: Date of last full mouth xary: Defend one at you last dental visit? Previous Dentist Name Comment Address Comment Down often do you bruth? How often do you bruth? How often do you bruth? How often do you use? (bothgick, waterpick, etc.) Do you have early dental problems non? Pres No Mouth breath Yes No If yes Have tred jaws, especially in the morning If yes Have tred jaws, especially in the morning If yes Have you experienced: Clicking or Popping of the jaw Yes No Do your pure last early with your teeth (pends, pine, nals, pipe) Yes No Meter you experienced: Clicking or Popping of the jaw Yes No Sore muckeleneks or Shoulder) Prequent close Ardw, shoulder arthe Yes No Sweetts Prequent close Ardw, shoulder arthe Yes No Odor or had taste Yes No Mouth the early in the eving Yes No Have your parents experienced gun disease or tooth lose? Yes No Have you repress experienced gun disease or tooth lose? Yes No Have you repress experienced gun disease or tooth lose? Yes No Are your teeth senative cost mentifuraces) Yes No Are your teeth senative to: Not often don't serve in the morning Yes No Are your teeth senative cost mentifuraces) Yes No Are your teeth senative cost mentifuraces) Yes No Are your teeth senative cost mentifur cost of the senative cost of the senative cost of the senative cost of t		Comment				
Date of last dental dearing: Date of last full mouth xray: What was done at your list dental vist? Comment Previous Dentist Name Comment Address Addr	·					
Date of lost full mouth xray: What was done at your lost dental visit? Comment Address Comment How often do you brush? How often do you loss? What other dental aids do you use? (toothpick, waterpick, etc.) Do you have any dental problems now? Yes No Soore Tyes No Soore Tyes No Soore Tyes No Soore Tyes No Thew your fingernals The your fingernals The your teeth (pendis, pris, nalis, pipe) The your teeth (pendis, pris, nalis, pipe) The your veperienced: Clicking or Popping of the jaw Have tred jaws, especially in the morning The yes No Frequent cold sores The your teeth (pendis, pris, nalis, pipe) The yes No The your teeth prison of yes No The ye						
What was done at your last dental visit? Comment Comment	_					
Previous Dentist Name Address Comment Comment	•					
Address Comment		Comment				
Phone number Comment How often do you brush? How often do you brush? How often do you floss? What other dental aids do you use? (toothpick, waterpick, etc.) Do you have any dental problems now? Do you have any dental problems now? Do you have othy or well water? DO YOU: Clonch or grind your teeth Yes No Mouth breath Yes No Have any sleeping disorder Yes No Hold foreign objects with your teeth (pendis, pins, nalis, pipe) Yes No Yes No Frequent cold sores Yes No Headaches, neck ache, shoulder aches Yes No Frequent cold sores Yes No Sore musclesjneck or Shoulder) Frequent cold sores Yes No Sore musclesjneck or Shoulder) Frequent cold sores Yes No Sore musclesjneck or Shoulder) Yes No Odor or bad taste Yes No Are your teeth seprefenced gum disease or tooth loss? Yes No Do you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Do you spuns bleed or hunt? Have you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you onoticed any loose teeth or change in you bite? Yes No Have you noticed any loose teeth or change in you bite? Yes No Yes No Fireguent bleator treatment(praces) Yes No Yes No Yes No Able Plate or mouth guard		Comment				
How often do you have dental examinations? How often do you foss? What other dental aids do you use? (toothpick, waterpick, etc.) Do you have any dental problems now? Do you have any dental problems now? Do you have any dental problems now? Do you have city or well water? DO YOU: Clend nor grind your teeth	Address	Comment				
How often do you brush? How often do you flose? What other dental aids do you use? (toothpick, waterpick, etc.) Do you have any dental problems now? Or you water? Or you. If yes Have any sleeping disorder Yes No Head aches, neck ache, shoulder aches Yes No Frequent cold sores Or yes No Frequent cold sores Or yes No Or yes No If yes No Or yer yer yer yer yer yer yer yer yer ye	Phone number	Comment				
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What other dental aids do you use? (toothpick, waterpick, etc.) Do you have any dental problems now? Do you have any dental problems now? Do you have othy or well water? DO YOU: Clench or grind your teeth Mouth breath Yes No How any sleeping disorder Yes No Hold foreign objects with your teeth (pencils, pins, nalis, pipe) Have tred jaws, especially in the morning If yes Have you experienced: Clicking or Popping of the jaw Have you experienced: Clicking or Popping of the jaw Frequent cold sores Yes No Frequent cold sores Yes No Frequent blisters or or al lesions Are your teeth sensitive to: Hot or Cold Yes No Sweets Sweets Yes No Have you apms bleed or hurt? Have you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Trequent blisters or or all esions Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you parents experienced gum disease or tooth loss? Yes No Have you ever had: Orthodontic treatment(braces) Yes No If yes No A bite Plate or mouth guard Yes No A bite Plate or mouth guard Yes No A bite Plate or mouth guard Yes No	How often do you brush?					
etc.) Do you have any dental problems now? Do you have any dental problems now? Do you have city or well water? DO YOU: Clench or grind your teeth	How often do you floss?					
Do you have city or well water? Do YOU: Clench or grind your teeth		Comment				
DO YOU: Clench or grind your teeth Yes No Mouth breath Yes No Have any sleeping disorder Yes No Have any sleeping disorder Yes No Have tried jaws, especially in the morning If yes Have tried jaws, especially in the morning If yes Have you experienced: Clicking or Popping of the jaw Yes No Frequent cold sores Yes No Prequent blisters or oral lesions Are your teeth sensitive to: Hot or Cold Yes No Sweets Yes No Sweets Yes No Sweets Yes No Biting or chewing Yes No Biting or chewing Yes No Tryes No Tryes Have your gums bleed or hurt? Have your parents experienced gum disease or tooth loss? Yes No Do your gums bleed or hurt? Yes No Tryes No	Do you have any dental problems now?	○ Yes ○ No If yes				
Clench or grind your teeth	Do you have city or well water?					
Clench or grind your teeth	DO VOLI					
Mouth breath		our lips or cheeks regularly		Chew your fingernails		
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 Headaches, neck ache, shoulder aches Yes No Frequent cold sores Yes No Frequent cold sores Are your teeth sensitive to: Hot or Cold Yes No Sweets Yes No Biting or chewing Yes No Do your gums bleed or hurt? Have you parents experienced gum disease or tooth loss? Have you noticed any loose teeth or change in you bite? Does food tend to become caught in between your teeth? If yes No If yes No If yes No If yes No Oral surgery Yes No A bite Plate or mouth guard Yes No A bite Plate or mouth guard Yes No A bite Plate or mouth guard Yes No Oral surgery Yes No A bite Plate or mouth guard Yes No				_		
Have tred jaws, especially in the morning	Have any sleeping disorder Yes No					
Have you experienced: Clicking or Popping of the jaw	Hold foreign objects with your teeth (pencils, pins, nails, pipe)					
Clicking or Popping of the jaw	Have tired jaws, especially in the morning					
Headaches, neck ache, shoulder aches	Have you experienced:					
Are your teeth sensitive to: Hot or Cold		n in joint, ear or side of face		Difficulty in chewing	Yes No	
Are your teeth sensitive to: Hot or Cold				Odor or bad taste	Yes No	
Hot or Cold	Frequent cold sores Yes No Fred	quent blisters or oral lesions	⊕ Yes ⊕ No			
Do your gums bleed or hurt? Yes No	Are your teeth sensitive to:					
Have you noticed any loose teeth or change in you bite? Over the policy of the policy	Hot or Cold	ts		Biting or chewing		
Have you noticed any loose teeth or change in you bite? Over the policy of the policy	<u> </u>			I		
Have you noticed any loose teeth or change in you bite? Does food tend to become caught in between your teeth? If yes, where Yes No Yes No If yes No If yes Have you ever had: Orthodontic treatment(braces) Periodontal treatment Yes No Yes No Your bite adjusted Yes No A bite Plate or mouth guard Yes No	Do your gums bleed or hurt?	Yes No				
Does food tend to become caught in between your teeth? If yes, where Yes No If yes Have you ever had: Orthodontic treatment(braces) Periodontal treatment Yes No Yes No A bite Plate or mouth guard Yes No	Have your parents experienced gum disease or tooth loss?					
If yes, where	Have you noticed any loose teeth or change in you bite?	○ Yes ○ No				
Have you ever had: Orthodontic treatment(braces)	Does food tend to become caught in between your teeth?	○ Yes ○ No				
Orthodontic treatment(braces)	If yes, where	○ Yes ○ No If yes				
Orthodontic treatment(braces)	Have you ever had:					
Periodontal treatment		do you wear a retainer	⊚ Yes ⊚ No	Oral surgery		
		bite adjusted		A bite Plate or mouth guard		
Are you satisfied with the appearance of your teeth?	Are you satisfied with the appearance of your teeth?	⊚ Yes ⊚ No		I		
Would you like to keep all your teeth all your life?	Would you like to keep all your teeth all your life?	○ Yes ○ No				
Do you feel nervous about having dental treatment?	Do you feel nervous about having dental treatment?					
If yes, what is your biggest concern	If yes, what is your biggest concern	If yes				
Have you had any serous injury to mouth or head?	Have you had any serous injury to mouth or head?					
Is there anything else about having dental treatment that you would like us to know?	Is there anything else about having dental treatment that you					
Would like us to know? CLINICAL NOTES ONLY	Would like us to know?	_				