Dental History

Patient Name_____ **Date of Birth**_____

SS/HIC/Patient ID#_____

Dental Clinic_____ **Dentist Name**_____

Street address_____ **City**_____ **State**_____

Phone _____ **Zip**_____

Date of Last Appointment_____ **Date of Last X-Rays**_____

Why did you leave your previous dentist?_____

	Yes	No		Yes	No		Yes	No
Bad breath	○	●	Orthodontic treatment	○	●	Food collection between the teeth	○	●
Bleeding gums	○	●	Wisdom teeth extracted	○	●	Sensitivity to cold	○	●
Gums swollen or tender	○	●	Bite problems	○	●	Sensitivity to hot	○	●
Sores, blisters, growths on lips or mouth	○	●	Missing teeth	○	○	Sensitivity to sweets	○	●
Burning sensation on tongue	○	●	Shifting position of teeth	○	○	Sensitivity when biting	○	●
Biting cheeks or lips	○	●	Chew on one side of mouth	○	●	Stained teeth	○	●
Dry mouth	○	●	Tobacco use	○	●	Grinding or clenching teeth	○	●
Mouth breathing	○	●	Chewing on foreign objects	○	●	Clicking or popping jaw	○	●
Chewing	○	●	Fingernail biting	○	●	Jaw pain or fatigue	○	●
Swallowing	○	●	Thumb sucking	○	●	Opening or closing jaw	○	●
Prominent gag reflex	○	●	Tongue thrusting	○	●	Pain around ear	○	●
Talking	○	●	Loose or broken fillings	○	●	Pain on brushing teeth	○	●
Periodontal treatment	○	●	Loose or broken teeth	○	●	Pyorrhea or trench mouth	○	●

How often do you brush?_____

How often do you floss?_____

How often do you have your teeth cleaned?_____

How often do you change your toothbrushes?_____