DENTAL HISTORY FORM

PENDLETON
FAMILY DENTISTRY

PATIENT NAME _____ Birth Date _____

Reason for this visit: _____

When your last Dental Visit was: _____ what was done: _____

Previous Dentist Name: _____

How Often do you brush: _____ How often do you floss: _____

Is your water fluoridated: _____

Do your gums bleed while brushing or flossing	Y☐N☐	Do you bit your lips or cheeks	Y☐N☐
Are your teeth sensitive to Hot or Cold	Y☐N☐	Have you noticed any loose teeth	Y☐N☐
Are your teeth sensitive to Sweet or or Sour Liquids/Foods	Y☐N☐	Does Food Tend to become caught between your teeth	Y☐N☐
Do you feel pain to any of your teeth	Y☐N☐	Have you ever had Periodontal treatment (gums)	Y☐N☐
Do you have any sores or lumps in or near your mouth	Y☐N☐	Ever worn a Bite Plate or other appliance	Y☐N☐
Have you ever had any Head, Neck, or jaw injuries	Y☐N☐	Have you ever had any difficult extractions in the past	Y☐N☐
Have you experienced any of the following:		Do you wear Partials or Dentures	Y☐N☐
Clicking	Y☐N☐	If Yes, Date of Placement: _____	
Pain (Joint, Ear, Side of Face)	Y☐N☐	Have you ever received Oral Hygiene instructions regarding the care of your teeth and gums	Y☐N☐
Difficulty in opening or closing	Y☐N☐		
Difficulty in chewing	Y☐N☐		
Do you have frequent headaches	Y☐N☐		
Do you clench or grind your teeth	Y☐N☐		

If you could change ANYTHING about your smile, what would you change?

_____

_____

_____

Patients Signature: _____ Date: _____