Time 11:28 AM

Maxson Dental, P.C.

Date 8/19/2019

Dental History

Patient Name:

Birth Date:

Date Created:

When was your last dental visit?

When were your last x-rays taken?

Are you having problems that require immediate attention? If so what? ○ Yes ○ No If yes

Do you require an anitbiotic premedication? ○ Yes ○ No

Are your teeth sensitive to...

- Hot? ○ Yes ○ No
- Cold? ○ Yes ○ No
- Chewing? ○ Yes ○ No

How do you take care of your teeth?

Are you happy with your smile? ○ Yes ○ No

Does food catch between any of your teeth? If so where? ○ Yes ○ No If yes

Do you have any broken teeth? If so where? ○ Yes ○ No If yes

Do your gums bleed or feel tender or swollen? ○ Yes ○ No

Do you have any missing teeth? If so where? ○ Yes ○ No If yes

Have they been replaced? If so, with what?

- ☐ Bridge
- ☐ Implant
- ☐ Complete Denture
- ☐ Partial Denture

Are you happy with your replacements? ○ Yes ○ No

Do you have fluoridated water? ○ Yes ○ No

Have you had orthodontic treatment (braces)? ○ Yes ○ No

Have you had your wisdom teeth removed? ○ Yes ○ No

Have you had periodontal treatment (gums)? ○ Yes ○ No

Do you grind or clench your teeth? If so when? ○ Yes ○ No If yes

Do you wake up with sore or tight jaw or neck muscles? ○ Yes ○ No

Do you have frequent headaches? ○ Yes ○ No

Does your jaw ever click, pop or grind? If so when? ○ Yes ○ No If yes

Do you have pain in or around your jaw joint or ears? ○ Yes ○ No

Do your muscles hurt when you chew? ○ Yes ○ No

Has your jaw ever locked...

- open ○ Yes ○ No
- closed ○ Yes ○ No

Does your jaw ever...

- slip ○ Yes ○ No
- stick ○ Yes ○ No

Does dental treatment make you feel unusually anxious? ○ Yes ○ No

Have you had bad experiences in the dental setting in the past? ○ Yes ○ No If yes

What is important to you in your oral health?

What do you expect from your dental care team?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changed in medical status.

Signature of Patient, Parent or Guardian:

X

Date: