DENTAL HISTORY

Patient name: | I.D. # | Date / /

1. What is your primary concern?
2. Is there anything you dislike about the looks of your teeth?
3. When was your last dental exam? Cleaning?
4. Have you been under regular care? Yes No
5. Why did you decide to change dentists?
6. Have you had any: Root canal? Yes No Gum treatment? Yes No
   Braces? Yes No Extractions? Yes No When?
   Why? Notes:
7. Do you have any replacements? Yes No When?
8. Do you snack between meals? Yes No Notes:
   Pop, Kool-aid, Coffee/Tea? How much?
9. How do you take care of your teeth on a daily basis?
   a.) Brushing: Hard Medium Soft
   b.) Flossing: Yes No How often?
   c.) Mouthwash: Yes No Brand?
   d.) Other:
   e.) Has a dentist or hygienist shown you how to brush and floss?
   Yes No
10. Do you ever notice your gums bleeding or tender when you brush or floss? Yes No Where?
    How long?
11. Do you have any problem with bad breath? Yes No Notes:
12. Do you have any problem with food packing between your teeth?
    Yes No Where?
13. Are you aware of any loose teeth? Yes No Where?
    How long?
14. Do you ever clench or grind your teeth? Yes No When?
15. Do you ever notice your jaw popping or clicking? Yes No
    How long? Any pain or limited opening?
16. Do you have any problems with frequent headaches? Yes No
    When?
    Where?
    How many a week?
17. Have you ever worn a bite plane, night guard, or had your bite adjusted? Yes No When?
18. Are there any other problems you feel we should be aware of?

19. PEDO: A.) Any injuries to face or teeth?
    B.) Are you or have you taken a fluoride vitamin or rinse?
    C.) Any habits?

TREATMENT EXPLANATION PATIENT: DATE: / /

TOOTH		EXISTING					SEALANT
	1						
	2						
	3						
A	4						
B	5						
C	6						
D	7						
E	8						
F	9						
G	10						
H	11						
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N	23						
O	24						
P	25						
Q	26						
R	27						
S	28						
T	29						
	30						
	31						
	32						
TOTALS							

SPECIALIST REFERRAL: _____