Beavers
FAMILY DENTISTRY

DENTAL HISTORY

How did you hear about us ? _____
What is the purpose of today's visit? _____
How long since your last dental visit? _____
What treatment did you receive? _____
Previous Dentist's Name: _____
Address: _____ Phone: _____
What did you like most about your last dentist? _____
Would you like to tell us anything else about your previous dental experience?_____
_____
How long has it been since you had your teeth professionally cleaned? _____

Please Circle Yes/No

Have you made regular visits?.....Yes No
How often? _____
Were dental radiographs taken? .....Yes No
Have you ever lost teeth or had them removed?.....Yes No
Why?_____
Have they been replaced? .....Yes No
If so, when and how were they replaced? _____
Are you unhappy with the replacement? .....Yes No
If yes, please explain: _____
Would you like to discuss replacement options?.....Yes No
Do you clench or grind your teeth?.....Yes No
Does your jaw click or pop? .....Yes No
Have you experienced pain or soreness in the muscles of your face? .....Yes No
Are any of your teeth sensitive to: ____Hot? ____Cold? ____ Sweet? ____ Pressure? ____ Biting?
Do your gums bleed or hurt?.....Yes No
If yes, when?_____
How often a day do you brush? _____
What type of toothbrush/toothpaste do you use? _____
Do you use a daily mouthwash? If so, what do you use? _____
How often do you floss? _____ What type of floss do you use? _____
Do you have any loose, broken or shifted teeth? .....Yes No
Are you unhappy with the appearance of your teeth? .....Yes No
Is there anything you would like to change about your teeth? .....Yes No
Have you ever had gum treatment or surgery? ..... Yes No
If yes, when? _____ What was done? _____
Have you ever had any complications following dental treatment? .....Yes No
If so, please explain: _____
Have you ever had orthodontics (braces) ? .....Yes No
Have you ever taken bisphosphonate medications? (ex: Fosamax).....Yes No
Do you have anything about dentistry that you strongly dislike or have any unpleasant experiences or concerns? _____

Patient/Guardian Signature: _____ **Date**: _____