Whispering Pines Dental Lodge
Family and Cosmetic Dentistry
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PATIENT DENTAL HISTORY

Patient's Name_____Date of Birth_____
Reason for this visit_____
When was your last dental visit_____What was done then_____
Previous Dentist (Name and Location)_____
When was the last time you had a complete series of dental films (x-rays) taken?_____
How often do you brush your teeth_____How often do you floss your teeth_____
Is your drinking water fluoridated_____

Do your gums bleed while brushing or flossing?	○Yes ○No
Are your teeth sensitive to hot or cold liquids or foods?	○Yes ○No
Are your teeth sensitive to sweet or sour liquids or foods?	○Yes ○No
Do you feel pain to any of your teeth?	○Yes ○No
Do you have any sores or lumps in or near your mouth?	○Yes ○No
Have you had any head, neck or jaw injuries?	○Yes ○No
Have you ever experienced any of the following:	
Problems in your jaw?	○Yes ○No
Clicking	○Yes ○No
Pain (Joint, Ear, Side of Face)	○Yes ○No
Difficulty in Opening or Closing	○Yes ○No
Difficulty in Chewing	○Yes ○No
Do you have frequent headaches?	○Yes ○No
Do you clench or grind your teeth?	○Yes ○No
Do you bite your lips or cheeks frequently?	○Yes ○No
Have you noticed any loosening of your teeth?	○Yes ○No
Does food tend to become caught between your teeth?	○Yes ○No
Have you ever had periodontal treatment (gums)?	○Yes ○No
Have you ever worn a bite plate or other appliance?	○Yes ○No
Have you ever had any difficult extractions in the past?	○Yes ○No
Have you ever had prolonged bleeding following extractions?	○Yes ○No
Do you wear dentures or partials? Date of placement_____	○Yes ○No
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	○Yes ○No

If you could change <u>anything</u> about your smile, what would you change?_____

Signature of Patient/Parent/Guardian_____Date_____