Glen Ellyn Smiles

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DENTAL HISTORY

NAME:____ **DATE:**___________________________________

What is the reason for your visit today? ____

Date of last dental visit? ______________ Last dental cleaning? _______________ Last full mouth x-rays? ______________

What was done at your last dental visit? ____

Previous Dentist

Name: ____ Phone number: ___________________________________

Address: ____

How often do you have dental exams? ____

How often do you brush your teeth? ________________________ How often do you floss? _____________________________

Do you use any other dental aids (Ex: electric toothbrush, toothpick, etc)? ____

Do you have any dental problems at this time? ___ Yes ___ No
If yes, please describe:

____

____

MARK ANY OF THE FOLLOWING YOU HAVE NOW OR HAVE HAD IN THE PAST

Sensitivity: ___ Hot ___ Cold ___ Sweets ___ Biting or chewing ___ Pressure

Do you:

___ Clench or grind (awake or asleep)
___ Bite lips or cheeks
___ Mouth breather (awake or asleep)
___ Tired jaws, especially in morning
___ Jaw pop or click
___ Smoke or chew tobacco
___ Get cold sores, blisters or other lesions
___ Notice any loose teeth, change in bite, tipped or shifted teeth
___ Notice any mouth odors or bad tastes
___ Notice your gums bleed or hurt
___ Notice food getting caught between teeth. If yes, where: _________________________

Have your parents experienced gum disease or tooth loss? ________________________________

Have you ever had:

___ Orthodontic treatment?
___ Oral Surgery?
___ Periodontal treatment?
___ Your teeth ground or bite adjusted?
___ A bite plate or mouth guard?
___ A serious injury to the mouth or head?
If yes, please describe: ____

Are you satisfied with your teeth? ____ Yes ___ No
If no, please explain: ____