Dental History

Do you have regular dental care? ☐ Yes ☐ No ☐ Don't Know

When was your last dental visit? ______________________

For what purpose? ______________________

When was your last cleaning appt? ______________________

When were your last dental x-rays taken? ______________________

Are you happy with the appearance with your teeth? ☐ Yes ☐ No ☐ Don't Know

Do you chew on both sides of your mouth? ☐ Yes ☐ No ☐ Don't Know

Are your teeth unusually sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

Are you difficult to get numb? ☐ Yes ☐ No ☐ Don't Know

Do your gums bleed when you brush? ☐ Yes ☐ No ☐ Don't Know

Have you ever had unusual swelling in your mouth? ☐ Yes ☐ No ☐ Don't Know

Do you have unusual or frequent pain in your: ☐ Teeth ☐ Jaw ☐ Jaw Joints ☐ Ears

Have you ever worn braces? ☐ Yes ☐ No

Have you ever been told you have a gum disease? ☐ Yes ☐ No ☐ Don't Know

Patient/Parent/Guardian Signature ______________________ Date ____________

Medical History Updates

Date: ____________ Changes: ______________________

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Signatures: ______________________

Date: ____________ Changes: ______________________

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Signatures: ______________________

Date: ____________ Changes: ______________________

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Signatures: ______________________

Date: ____________ Changes: ______________________

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Signatures: ______________________