Bullock Family Dental

Dental History

Dental History
Name:
Birthdate: ____/____/____
Why did you come to the dentist today?
Name of Previous Dentist:
Date of Last Visit: ____/____/____
When was your last cleaning?
Did you have x-rays at that time? Y N
How many times a day do you brush?
How many times a week do you floss?
Type of bristles on your toothbrush: hard ☐ medium ☐ soft ☐
Do you do anything else to clean your teeth? Y N If yes, what?
Do your gums bleed? Y N
Have you ever had gum disease? Y N
Have you ever had root planing or a deeper cleaning? Y N

Dental History Continued
Does food get caught between your teeth? Y N
Have you ever experienced problems associated with previous dental work? Y N
Do you have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N
Are you aware of any clenching or grinding? Y N
Do you have frequent headaches? Y N
Do you have problems eating certain foods? Y N If yes, what?
Are your teeth sensitive to hot, cold, or anything else? Y N If yes, explain.
Do you still have your wisdom teeth? Y N
Do you have any mobility in your teeth? Y N
Have you lost any teeth? Y N If yes, why?
If you could change one thing about your smile what would it be?

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature of Patient, Parent, or Guardian *Date*

_____

Signature of Dentist *Date*