DENTAL HISTORY

PATIENT NAME: _____ TODAY'S DATE: / /

What is your main reason for visiting the dentist today?: _____

Who was your previous dentist?: _____

When was your last dental visit? _____

How often do you visit the dentist? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

	Yes	No
Have you lost any teeth or had any teeth extracted?	☐	☐
If yes, what was the reason?		
Have you had any teeth replaced with:		
Dental Implants?	☐	☐
A Dental Bridge?	☐	☐
A Partial Denture?	☐	☐
A Complete Denture?	☐	☐
Do you have any teeth that are sensitive to:		
Hot?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐
Does food wedge between any of your teeth?	☐	☐
Do you ever clench or grind your teeth?	☐	☐
Do you have pain in or around either of your jaw joints?	☐	☐
Do you wear a night guard?	☐	☐
Have you ever had an injury to your head, face or neck?	☐	☐
Do you feel that you have occasional or frequent bad breath?	☐	☐
Do you have an unpleasant taste in your mouth?	☐	☐
Have you noticed any swelling, lump, or growth in or around your mouth?	☐	☐
Have you noticed any discolored areas on your head, face or neck?	☐	☐
Have you ever worn braces, invisalign, or a retainer?	☐	☐
Have you ever had gum treatments or gum surgery?	☐	☐

	Yes	No	Maybe
Are you interested in whitening your teeth?	☐	☐	☐
Are you interested in a Cosmetic Dental Consultation with Dr. Beiting?	☐	☐	☐