DENTAL HISTORY **Patient Name**:_____

What is the reason for your visit today?_____

_____

What is your biggest dental concern? _____

Date of last dental visit:_____ What was done?_____

Last full mouth x-rays:_____ Last dental cleaning:_____

Previous dentist's name:_____ Telephone:_____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

What dental hygiene aids do you use? (floss, electronic brush etc.)_____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to :			**Have you ever had:**		
Hot or cold	Yes	No	Orthodontic treatment	Yes	No
Sweets	Yes	No	Oral surgery	Yes	No
Biting or chewing	Yes	No	Periodontal (gum) treatment	Yes	No
			Your bite adjusted	Yes	No
Have you noticed bad odors or tastes?	Yes	No	A bite plate or mouth guard	Yes	No
Do you get mouth sores?	Yes	No	Serious mouth or head injury	Yes	No
Do your gums bleed or hurt?	Yes	No	If so please describe:_____		
Did your parents have gum disease or			_____		
tooth loss?	Yes	No	**Have you ever experienced:**		
Any loose teeth or change in your bite	Yes	No	Headaches or neck pain	Yes	No
Does food catch between your teeth?	Yes	No	Clicking or popping of your jaw	Yes	No
Where?_____			Pain in joint, ear or side of your face	Yes	No
			Hard to open or close mouth	Yes	No
			Difficulty chewing on one side	Yes	No
Do you:					
Clench or grind your teeth	Yes	No	Bite your lips or cheeks often	Yes	No
Hold things with your teeth	Yes	No	Breathe through your mouth	Yes	No
Have tired jaws	Yes	No			

Are you satisfied with your teeth's appearance?(please elaborate) _____

_____

If you could make your teeth **whiter** would you want to? Yes No

Are you nervous about dental treatment? Yes No Have you had an upsetting experience? Yes No

If yes, please describe:_____

Dental Design OF ROCKLAND

274 Old Nyack Tpk • Spring Valley, NY 10977 • (845)352-7545