DENTAL HISTORY

www.lakeside-dental.ca

Patient Name:_____ Date of Birth: _____

1.) Purpose of your visit today?_____

2.) Are you aware of any problems with your teeth &/or gums?_____

3.) How long has it been since you were last seen by a dentist?_____
How long has it been since your last professional dental cleaning?_____

4.) How often do you brush your teeth?_____ Floss your teeth?_____

5.) Indicate which of the following you previously or currently have been treated with by indicating Yes or No:

TREATMENT:	YES/NO
Fixed bridge……	○○
Crown……	○○
Removable partial denture……	○○
Complete denture……	○○
Implant……	○○
Gum disease treatment……	○○
Orthodontic treatment……	○○

6.) Indicate which of the following symptoms you experience by indicating Yes or No:

Hot/cold/sweet sensitivity……	○○
Pressure/biting sensitivity……	○○
Bleeding gums when flossing or brushing……	○○
Tender gums when flossing or brushing……	○○
Area(s) where food often traps……	○○
Clenching or grinding of teeth……	○○
Jaw clicking or popping……	○○
Pain or soreness in facial muscles or around ear….	○○
Frequent headaches or shoulder aches ……	○○
Chipped or broken teeth……	○○
Feel your breath is offensive at times……	○○

7.) Have you ever had any problems or complications with previous dental treatment?

8.) Are you unhappy with the appearance of your teeth?

9.) Have you had any unpleasant dental experience?

10.) Who referred you to our office?_____

I certify that the above information is complete and accurate.

_____ _____

(Patient/Guardian Signature) (Date) (Dentist's signature) (Date)

If Submitting Electronically – Printing your name above will be accepted.

RESET ALL