DENTAL HISTORY

Chavez Dental

Why have you come to the dental visit today?

- ☐ New Patient Initial Visit
- ☐ Emergency appointment
- ☐ Consultation
- ☐ Orthodontic Evaluation

Previous Dentist Name _____

Approximate date of last visit _____

Were you satisfied with your previous care? ☐ Yes ☐ No

Any specific dental problems that you are aware of?

_____

Your current dental health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Hopeless

To the best of your knowledge, do you have any of the following?

- ☐ Bleeding Gums
- ☐ Cavities
- ☐ Discolored Teeth
- ☐ Wisdom Tooth Pain
- ☐ Loose Teeth
- ☐ Crowded, Tipped or shifted teeth
- ☐ Toothache (were?) _____
- ☐ Sore Dentures
- ☐ Bad Breath
- ☐ Clinch or Grinding of Teeth
- ☐ Food Catching Between Teeth
- ☐ Chipped, Cracked or Broken teeth

Are your teeth sensitive to any of the following?

	Yes	No
Hot	☐	☐
Cold	☐	☐
Sweets	☐	☐
Biting/Pressure	☐	☐

Yes No

☐ ☐ Do you have dental exams on a regular basis?
Last visit: _____

☐ ☐ Do you have your teeth cleaned on a regular basis?
Last cleaning: _____

☐ ☐ Do you floss and brush on a regular basis?
Brush how often? _____
Floss how often? _____

☐ ☐ Have you ever had braces?
When ? _____

☐ ☐ Gum treatment or surgery?
When ? _____

Yes No

☐ ☐ Any pain with muscles of jaw or face?

☐ ☐ Frequent clicking, popping in jaw joints (TMJ)?

☐ ☐ Do you feel nervous about having dental appts?

☐ ☐ Problem or complications with previous work?

☐ ☐ Do you have any questions or concerns this dental history did not cover. If so, please explain,

_____

_____

_____

_____

For office use only

NOTES:

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