barkley village family dentistry

Dental History

Referred by _____

Previous dentist _____ How long _____

Last dental exam _____ Last dental x-ray _____

Last dental treatment _____

How often do you have your teeth cleaned? 3 mo ____ 4 mo ____ 6 mo ____ 1 yr or longer ____

What is your immediate dental concern? _____

Check if you have, or ever had the following:

- ☐ unhappy with appearance of your teeth
- ☐ are you interested in learning more about teeth whitening
- ☐ unfavorable dental experiences
- ☐ dental fears
- ☐ preference for no dental anesthetic
- ☐ problems with effectiveness or bad reactions to dental anesthetic
- ☐ have you used nitrous oxide (laughing gas) for dental tx
- ☐ orthodontic treatment (braces) when _____
- ☐ periodontal (gum) treatment when _____
- ☐ bleeding gums
- ☐ avoid brushing any part of your mouth
- ☐ part of your mouth is sensitive to temperature
- ☐ sore teeth
- ☐ a burning sensation in your mouth
- ☐ difficulty swallowing
- ☐ gag reflex
- ☐ an unpleasant taste or odor in your mouth
- ☐ jaw problems (temporomandibular joint)
- ☐ difficulty opening your mouth widely
- ☐ stiff neck muscles
- ☐ awaken with an awareness of your teeth or jaws
- ☐ tension headaches
- ☐ clench or grind your teeth
- ☐ jaw clicking or popping
- ☐ lost any permanent teeth

Supplemental denture history:

If you are wearing a partial or complete artificial denture, please complete the following:

Yes	No	
☐	☐	Has your present denture been relined? When? _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Dentist's Remarks _____

_____ Rev. _____