

# DENTAL HISTORY

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

1. When was your last visit to the dentist (approximately): \_\_\_\_\_  
What was it for: \_\_\_\_\_
  2. When was your last professional dental cleaning: \_\_\_\_\_
  4. Approximately when were your last dental radiographs (x-rays): \_\_\_\_\_
  4. How often do you receive dental treatment, or dental hygiene care: \_\_\_\_\_
  5. Are you under the care of a dental specialist? (ie) an orthodontist, endodontist, prosthodontist, periodontist \_\_\_\_\_
- |  | Yes | No | Not Sure |
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Do you have or have you ever experienced any of the following (please circle which ones):

- Sensitive teeth (hot or cold) • cold sores • bleeding gums when brushing • sore gums • mouth sores
- Loose teeth • dry mouth • recession • bad breath • swelling in your mouth or face area • difficulty chewing
- Sore jaw • jaw clicks or pops on opening or closing • difficulty swallowing • burning sensation
- Calculus (tartar build-up • toothache • fractured or broken filling • tooth infection (abscess)
- Yellow or discolouration of teeth • accident or injury or surgery to your face, jaw or teeth

Is there any additional information or comments you would like to add? \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name (print): \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_