

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: _____