reardon DENTISTRY

Patient _____ Birth Date _____

DENTAL HISTORY

1. Former Dentist _____ Address _____

2. When did you last visit a dentist? _____ X-Rays taken? ◯ Yes ◯ No

If X-Rays were taken: ◯ Full Mouth Series ◯ Bitewing (molar only)

What was done at that time? _____

Why did you leave the dentist? _____

Has any dental treatment been recommended to you that you have not done? _____

_____

_____

3. Are you aware of any dental problems? ◯ Yes ◯ No Explain: _____

_____

_____

4. What do you feel is the present condition of your mouth? _____

_____

5. Have you ever been treated for gum disease? ◯ Yes ◯ No If yes, what was done? _____

_____

6. Are your teeth sensitive to: ◯ Sweet ◯ Cold ◯ Heat ◯ Pressure ◯ Nothing

7. Are you happy with the appearance of your smile? ◯ Yes ◯ No Explain: _____

_____

_____

_____

8. Are you concerned with bad breath (malodor)? ◯ Yes ◯ No

9. Are you concerned with snoring or sleep apnea? ◯ Yes ◯ No

10. Are you concerned with grinding your teeth (bruxism)? ◯ Yes ◯ No

11. Are you aware of possible TMJ problems – does your jaw make noise or lock up? ◯ Yes ◯ No

12. Is there anything else that would be valuable for your dentist to know? _____

_____

_____

_____

_____

Patient Signature _____ Date _____