Dental History

Chart No | | | | | | |

QUESTIONS	RECORD YOUR RESPONSE BELOW
What is the purpose of your dental visit?	
How long since your last dental visit?	
What was done at that time?	
Dentist name and address:	
How do you feel about your teeth in general?	
How often do you brush your teeth?	
When was the last time your teeth were cleaned?	

RESPONSE	QUESTIONS
[ ] yes [ ] no	Is there anything about dentistry that you strongly dislike? If yes, what? ______________________
[ ] yes [ ] no	Are you unhappy with the appearance of your teeth? If yes, why? __________________________
[ ] yes [ ] no	Does food get caught in your teeth?
[ ] yes [ ] no	Do you use dental floss?
[ ] yes [ ] no	Do your gums bleed or hurt?
[ ] yes [ ] no	Are any of your teeth sensitive to hot or cold?
[ ] yes [ ] no	Are any of your teeth loose, chipped, or shifted?
[ ] yes [ ] no	Do you clinch or grind your teeth?
[ ] yes [ ] no	Does your jaw click or pop?
[ ] yes [ ] no	Do you feel your breath is offensive at times?
[ ] yes [ ] no	For adults only, have you lost any teeth or have any teeth been removed?
[ ] yes [ ] no	Have they been replaced?
[ ] yes [ ] no	Are you happy with the replacement?
	How long have you had your replacement? _______________________________________
	[ ] dentures [ ] removable bridge [ ] fixed bridge
[ ] yes [ ] no	Have you experienced any pain or soreness in the muscles of your face or around your ear?
[ ] yes [ ] no	Do you have frequent headaches, neck aches, or shoulder aches?
[ ] yes [ ] no	Have you ever had gum treatment or surgery?
[ ] yes [ ] no	Have you had any orthodontic work?
[ ] yes [ ] no	Were dental x-rays taken?
[ ] yes [ ] no	Have you made regular visits?
[ ] yes [ ] no	Have you been diagnosed with gum disease?
[ ] yes [ ] no	Do you have any questions or concerns? If yes, what are they? ___________________________

I understand that the above information is necessary to provide me with safe dental care, and I have answered all the questions to the best of my knowledge. In addition, I authorize Arundel Mills Dental Group to obtain clarification or additional information from the respective healthcare providers or agencies identified on this form to facilitate diagnosis and treatment. I certify that the above information is complete and accurate.

Print Patient Name ____________ Patient or Parent/Guardian's Signature ____________ Date ____________

Doctor's Signature ____________ Date ____________