GROVE PARK DENTAL – DENTAL HISTORY

PATIENT NAME _____ DOB ____/____/_____

What is the reason for your visit today? _____

_____

_____

_____

PREVIOUS DENTIST:

Name _____

Address _____

_____

Phone # _____

How often do you:

Brush? _____

Floss? _____

What other dental aids do you use?

_____

LAST DENTAL VISIT ____/____/_____

LAST DENTAL CLEANING ____/____/_____

LAST FULL MOUTH X-RAYS ____/____/_____

Are your teeth sensitive to:

Hot or Cold?	[ ] Y [ ] N
Sweets?	[ ] Y [ ] N
Biting or Chewing?	[ ] Y [ ] N

Have you noticed any:

Mouth odors?	[ ] Y [ ] N
Bad tastes?	[ ] Y [ ] N
Loose teeth?	[ ] Y [ ] N
Change in bite?	[ ] Y [ ] N

Do your gums:

Bleed?	[ ] Y [ ] N
Hurt?	[ ] Y [ ] N

Does food get caught between your teeth? [ ] Y [ ] N

Do you:

Snore?	[ ] Y [ ] N
Have a sleeping disorder?	[ ] Y [ ] N

Have you ever had:

A bite plate/mouth guard?	[ ] Y [ ] N
Orthodontic treatment?	[ ] Y [ ] N
Periodontal treatment?	[ ] Y [ ] N

Have you experienced:

Jaw clicking or popping?	[ ] Y [ ] N
Joint, ear, or facial pain?	[ ] Y [ ] N
Difficulty opening or Closing your mouth?	[ ] Y [ ] N
Head, neck or shoulder aches?	[ ] Y [ ] N

Is there anything else you'd like us to know about your dental health? [ ] Y [ ] N IF YES, EXPLAIN:

_____

_____

_____