

Loudoun Dental Smiles

DENTAL HISTORY

Patient's Name _____

What is the main reason for your visit today? _____

When was your last dental exam? _____ Previous Dentist's name: _____

What was your reason for transferring? _____

What did you like most about your former dental office? _____

What did you like least about your former dental office? _____

How often do you? 1. Have dental exams and cleaning? _____ 2. Brush your teeth? _____ 3. Floss your teeth? _____

What other dental aids do you use? (Electric toothbrush, Interplak, toothpick, etc.) _____

Are your teeth sensitive to:

Hot, cold, sweets? Yes No

Biting or Chewing Yes No

Do you ever have mouth odor or bad taste? Yes No

Do your gums bleed or hurt: Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Do you have a history of gum disease in your family? Yes No

Does food tend to get caught between your teeth? Yes No

If yes, Where? _____

Do You:

Have a desire for whiter/brighter teeth? Yes No

Have a desire for cosmetic dentistry? Yes No

Clench or grind your teeth while asleep or awake? _____ Yes No

Bite/chew your lips or cheeks? Yes No

Mouth breathe while asleep or awake? _____ Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Have you ever experienced:

Clicking or popping of your jaw? Yes No

Pain? (joint, ear, face) Yes No

Headaches/neckaches? Yes No

I understand the above information is necessary in to provide safe, effective dental care. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I authorize this office to administer such medications and perform such diagnostic/therapeutic procedures as may be necessary.

Signature: _____ Date: _____