DENTAL HISTORIES

WEST ETOBICOKE DENTAL CENTRE

NAME: ____ **DATE OF BIRTH**: ________ /________ /____________
GIVEN NAME FAMILY NAME DAY MONTH YEAR

Are you experiencing any dental problems? (YES / NO) Date of your last dental visit: ______________________

When was your last dental cleaning: _________________ **When was your last X-rays taken:** __________________

1. Have you been seeing a dentist regularly? -- YES /NO

2. Are there any growths or sore spots in your mouth? -- YES /NO

3. Have you noticed any loose teeth, or have any of your teeth shifted? --- YES /NO

4. Does food get caught between your teeth? --- YES /NO

5. Are any of your teeth sensitive to heat, cold, sweets or pressure? -- YES /NO

6. Have you been advised to take antibiotics before a dental appointment? -- YES /NO

7. Do you use dental floss, proxabrush, or stimudents? --- YES /NO If yes, how often: ________________________________

8. How often do you brush your teeth? _______________________ Do you feel that you have bad breath? ---------- YES /NO

9. Have you ever had on of the following?
( ) Periodontal Treatment: Treatment of the gums ( ) Orthodontic Treatment: to straighten or realign teeth
( ) A bite adjusted or any other appliance ( ) Your bite adjusted or teeth ground
( ) Oral Surgery: Surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints.

10. JAW PROBLEMS – Do you have any of the following?
( ) Popping/ Clicking in your jaw joints ( ) Pain in your jaw joints, around your ear, or side of your face
( ) Difficulty in opening or closing ( ) Pain when teeth are clenched
( ) Pain/ Difficulty in chewing

11. Do you have any of the following habits?
( ) Clenching or grinding your teeth while awake or asleep ( ) Biting your cheeks or lips regularly
( ) Breathing through your mouth while awake or asleep ( ) Hold foreign objects with your teeth (pencils, nails, etc.)

12. Do you have any emotional concerns about having dental treatment? --YES /NO

13. Are you happy with the appearance of your teeth? ---YES /NO
If no, what would you like to see changed?____

14. Have you ever had an upsetting experience in a dental office, or any complications during of following dental treatment, or do you have any questions or concerns? ____

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE:____________________________________**DATE:** ____________________

DENTIST SIGNATURE: ____**DATE:** ____________________