DENTAL HISTORY

DATE_____ NAME _____

PLEASE ANSWER ALL QUESTIONS.

Approximately how long ago was your exam and cleaning? _____

Are you having any issues with your teeth (sensitivity, broken fillings, or teeth) or your Gums (swelling or irritation) If yes, please explain:

Do you wear removable Dentures or partials? Y or N Do they fit comfortably? Y or N

Have you ever had periodontal (Gum/ Bone) Surgery? Y or N When?

Are you experiencing any Dry Mouth symptoms? Y or N if Yes, what products do you use for relief?

_____

Circle if you use a POWER or MANUAL toothbrush? _____ How often do you replace the brush head or brush? _____

What type of toothpaste do you currently use? _____

How many TIMES a day do you Brush? _____ Floss? _____ please circle what type of floss:

STRING FLOSS or FLOSS STICKS?

IS there anything else you would like to tell us about your Dental concerns?

IN THE LAST 6 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING:

HEART ATTACK____BYPASS SURGERY____CARDIAC STENTS OR PACEMAKER PLACED____

JOINT REPLACEMENT____ IF YOU ANSWERED YES, PLEASE PROVIDE DATES: _____