

Cedar Valley Dental

Patient Name: _____ Date: _____

Dental History

Primary reason for dental appointment: Exam Emergency Consultation
Do you have a specific dental problem? _____ Describe _____
Do you have a dental examination on a regular basis? _____ Last visit? _____
Are your teeth sensitive to Cold? Hot? Sweet? Biting? Touch?
How would you describe your present dental health: Good Fair Poor
Do you think you have active decay (cavities)? Yes No
Do you think you have gum disease? Yes No
Do your gums bleed? Yes No
Do you have bad breath? Yes No
Have you ever been taught to control dental disease? Yes No
How often do you brush? _____ Floss? _____
Have you ever had Gum Surgery? TMJ (Jaw Joint) Therapy? Braces?
Do you ever have clicking, popping, or discomfort in the jaw joint? _____
Do you clench or grind your teeth? _____ When? _____
Do you smoke or chew tobacco products? _____ How much / long? _____
Do you have any sores or growths in your mouth? _____

Are you pleased with the appearance of your teeth; your smile? Yes No
If not, please explain: _____
Are your teeth all in alignment (straight)? Yes No
If not, please explain: _____
Do you have spaces that you do not like? Yes No
If yes, please explain: _____
Do you like the color of your teeth? Yes No
If not, please explain: _____
Do you like the shape of your teeth? Yes No
If not, please explain: _____
Are your teeth wearing or chipped on the biting surfaces? Yes No
If yes, please explain: _____
Are there old fillings or dental work you don't like? Yes No
If yes, please explain: _____
Please describe any changes you would like to make in the appearance of your teeth:

Have your past dental experiences always been positive? Yes No
Describe _____

Do you feel that you need: Major Some Very little (if any) Dental work?

Name of previous dentist (optional) _____
Date of last full mouth x-rays (16 small films or panoramic) _____

Doctor's Comments: _____

Signature of Patient or Responsible Party: _____

Date: _____