CEDAR VALLEY DENTAL

Pompilia C. Belean, D.D.S.

DENTAL HISTORY

Patient Name: _____ Date: _____

Primary Reason for dental appointment: □ Routine Exam □ Emergency □ Consultation/Second Opinion

Do you have a specific dental problem? _____

Have you had routine dental care in the past? _____ Date of last dental exam: _____

Are your teeth sensitive to: □ Cold □ Hot □ Sweet □ Biting □ Touch For how long? _____

Describe your current dental health: □ Great □ Good □ Fair □ Poor

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed? _____ Do you have bad breath? _____

Have you ever had: □ Gum surgery (Periodontal Surgery) □ Braces □ TMD therapy (Jaw joint therapy)

Do you ever experience any clicking or popping sounds, or any discomfort in your jaw joint? _____

Do you clench or gind your teeth? _____ When? _____

Do you smoke or chew tobacco products? _____ How much/how long? _____

Do you have any sores or growths in your mouth? _____

If displeased with your mouth or smile, please explain: _____

Are your teeth in alignment (straight)? _____

Do you have any spacing between your teeth you dislike? _____

Do you dislike the color of your teeth? _____

Are your teeth wearing on the biting/chewing surfaces? _____

Do you have old dental work that you dislike the look of? _____

Please explain any changes that you would like to make to your teeth not described above: _____

_____

Have your past dental experiences all been positive? _____

Previous dentist: _____

Date of last Full Mouth X-rays (FMX) or Panoramic X-ray: _____

Doctor's Comments: _____

_____

Signature of Patient/Responsible Party: _____ Date: _____