Davey Family Dentistry

DENTAL HISTORY

NAME_____DATE_____
Reason for today's visit?_____
Last Dental visit?_____ with us ( )YES ( )No (if no) Former dentist_____
City/State_____Date of last dental x-rays_____
Have you ever had a serious problem associated with previous dental treatment? ( ) YES ( ) NO
if yes, explain _____
How often do you brush? _____
How often do you floss? _____
What dental aids do you use? ( ) Floss ( ) Water pick ( ) toothpick ( ) Electric toothbrush ( )Sonicare toothbrush
( ) perio aid ( ) Other _____

Are you familiar with the term 'Preventive Dentistry'? ( )YES ( ) NO
When used properly, do you believe in the dental benefits of Fluoride? ( )YES ( ) NO
Do you plan on maintaining your teeth for the rest of your life? ( )YES ( ) NO
Do you have any present dental concerns? ( )YES ( ) NO
If Yes, explain_____
_____

PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU:

( ) Gums Bleed during brushing or flossing
( ) Gums feel tender or swollen
( ) Pain with brushing or flossing
( ) Frequent sensitivity to cold, hot or sweets
( ) Usually break teeth or fillings
( ) Pain with biting or chewing
( ) Jaws frequently feel tired or sore
( ) Regularly clench or grind your teeth
( ) Bad odors or tastes in mouth
( ) Pain around Ear
( ) Currently (or Previously used a mouth guard or splint
( ) Frequent cold sores, blisters or other oral/lip lesions
( ) Food frequently gets caught between teeth
( ) Previous (or current) Periodontal (gum) surgery
( ) Pervious (or current) Orthodontics (braces)
( ) Previous (or current) injury or trauma to your teeth, mouth, face
( ) Previous (or current) biopsy of mouth, lips or face
( ) Took fluoride as a child, or grew up drinking water w/ fluoride
( ) Dry mouth

SMILE EVALUATION:

Do you have concerns about? (Please check all the apply)

( ) Color of teeth
( ) Gaps or spaces between teeth
( ) Size of teeth
( ) Symmetry of teeth
( ) Teeth chipped or broken
( ) Front teeth
( ) Inflamed or bleeding gums
( ) Shape of teeth
( ) Show to much gum
( ) Position of teeth (crooked or crowded)
( ) Discolored restorations (existing crowns, fillings..)
( ) Back teeth

Other_____
_____

Is there anything you would like to discuss about your smile?_____
_____