Thornydale Dental

Dental History

Patient Name:_____

1. Please describe the primary reason for your visit (concerns): _____

_____

_____

2. Your current dental health is: Good____ Fair____ Poor____ Unsure____

3. Are you currently having any dental pain? Yes____ No____

4. Do you now or have you had any pain / discomfort in your jaw joint (TMJ)? Yes____ No____

5. Are you under any new or unusual stress? Yes____ No____

6. Are your teeth sensitive to cold, heat, sweets or anything else? Yes____ No____

7. Do your gums bleed? Yes____ No____

8. How often do you: floss / week_____brush / day_____

9. Have you ever had gum (periodontal) treatment or surgery? Yes____ No____

If yes, please describe when and what was done._____

10. Have you ever suffered from or been told you may have any of the following:

-Gum disease Yes____ No____ **-Malocclusion or bite problems Yes____ No____**

-Bruxism or Grinding Yes____ No____ **-Bad Breath Yes____ No____**

-Jaw Pain or Popping Yes____ No____ **-Headaches or Migraines Yes____ No____**

11. Do you like your smile? Yes____ No____

12. Are you happy with the color of your teeth? Yes____ No____

13. Is there anything you would like to change about the appearance of your teeth? Yes____ No____

14. Have you ever had a serious / difficult problem with any previous dental work? Yes____ No____

15. Have you ever had any unfavorable dental experiences? Yes____ No____

16. When was your last dental visit and what was the procedure?_____

17. Why did you leave your previous dentist?_____

18. How can we best accomodate you during your dental visit?_____