PECAN PARK FAMILY DENTISTRY

DENTAL HISTORY FORM

Patient Name_____ DOB _____ Date _____

Previous Dentist _____ How long were you a patient? _____

Date of most recent dental exam _____ Date of most recent x-rays _____

Date of most recent treatment (other than cleaning) _____

I routinely see my dentist every: ○ 3 months ○ 4 months ○ 6 months ○ 12 months ○ Not routinely

What is your primary concern? _____

	YES	NO
Have you had an unfavorable dental experience?	○	○
Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) [_____]	○	○
Have you ever had complications from past dental treatment?	○	○
Have you ever had trouble getting numb or had any reactions to local anesthetic (Novocaine)?	○	○
Have you had any teeth removed?	○	○
Is there anything you would like to change about your smile?	○	○
Have you ever whitened your teeth?	○	○
If no, would you like them whiter?	○	○
Would you like to straighten your teeth using **Invisalign**?	○	○
Have you been disappointed with the appearance of previous dental work?	○	○
Do you have problems with your jaw joints? (i.e. pain, popping, clicking, locking, limited opening)	○	○
Do you chew ice, bite your nails, or have any other oral habits?	○	○
Do you clench your teeth in the daytime or when you sleep?	○	○
Do you wear or have you ever worn a bite appliance?	○	○
Have you had any cavities within the past three years?	○	○
Does your mouth ever feel dry, or do you feel like you have too little saliva?	○	○
Are any of your teeth sensitive to hot, cold, sweets, or brushing?	○	○
Do you get food caught between your teeth?	○	○
Do your gums bleed when you brush or floss?	○	○
Is there a history of periodontal (gum) disease in your family?	○	○
Have you ever been diagnosed with or treated for periodontal (gum) disease?	○	○
Are you aware of any gum recession in your mouth?	○	○
Are any of your teeth chipped, broken, or loose?	○	○

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

What type of toothbrush do you use? Soft Medium Hard Electric

I certify that the above information is complete and correct.

Patient's Signature_____ Date: _____

Doctor's Signature _____ Date: _____