Patient Dental History

G² Dental
family dentistry

Patient's Name: ___________________________

Date of Birth: ___________________________

Reason for this visit: ___________________________

When was your last dental visit? ______________ What was done then? ______________

How often did you visit the dentist before then? ___________________________

Previous dentist (name and location): ___________________________

Have you had a complete series of dental films (x-rays) Taken? Yes No When? ______________

Where? ___________________________

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

Is your drinking water fluoridated? ___________________________

	YES	NO
Is it important for you to keep your teeth?	☐	☐
Is it important to better the function of your teeth?	☐	☐
Does food frequently get caught between teeth?	☐	☐
Do your gums often bleed while brushing?	☐	☐
Have you noticed loosening of your teeth?	☐	☐
Have you injured your head, neck, or jaw?	☐	☐
Do you have difficulty eating or swallowing?	☐	☐
Do you have a dry mouth?	☐	☐
Have you had a change in your ability to taste foods?	☐	☐
Problems of the Jaw – Have you noticed:		
Clicking of the jaw?	☐	☐
Pain (Joint, ear, side of face)?	☐	☐
Difficulty opening or closing?	☐	☐
Difficulty chewing?	☐	☐
Oral habits: Do you:		
Clench or grind your teeth?	☐	☐
Bite your lips or cheek frequently?	☐	☐

	YES	NO
Have you had:		
Orthodontic treatment (braces)?	☐	☐
Oral surgery?	☐	☐
Gum treatment	☐	☐
Your bite adjusted?	☐	☐
A bite plane/guard or other appliance?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

If you could change anything about your smile, what would you change? ___________________________

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If you had to rate your smile from 1-10 with 1 being the worst & 10 being best, what would you give yourself?

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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ___________________________ ______________

Signature of patient or parent if minor Date

___________________________ ______________

Doctor's Signature Date

POS Reorder # 1916061