Indian Creek Dental Patient Dental History

Patient Name: ______________________________ Date of Birth: ______________

Please state the reason for today's visit: ______________________________

Date of last visit to a dentist: ______________ Reason for last dental visit: ______________________________

Date of last dental cleaning: ______________ Previous dentist/dental office: ______________________________

How often do you brush?: 3+ times a day 2 times a day once a day weekly seldom

How often do you floss?: 1+ times a day 2-6 times weekly 1-6 times monthly seldom never

Do you use other dental aids (circle all that apply): electric/power toothbrush toothpicks floss aids Waterpik other:________

Do you have or have you ever had:

Bad Breath or Bad Tastes O Yes O No
Tooth Loss Due to Gum Disease/Bone Loss O Yes O No
Food Traps Between Your Teeth O Yes O No
Periodontal (Gum) Treatment O Yes O No
Sensitive Teeth to Biting/Chewing O Yes O No
Cold Sores, Canker Sores, Oral Lesions O Yes O No

Bleeding or Tender Gums O Yes O No
Sensitive Teeth to Hot/Cold O Yes O No
Sensitive Teeth to Sweets O Yes O No
Mouth Breathe O Yes O No
Dry Mouth O Yes O No
Lumps in Your Mouth O Yes O No

Do you wear partials or dentures? O Yes O No If yes, how long have you had them: ______________________

Have you had orthodontic treatment (braces)? O Yes O No If yes: When: ____________ Do you wear a retainer: O Yes O No

Have you been told you clench or grind your teeth? O Yes O No If yes, do you wear a nightguard: O Yes O No

Have you ever had a serious injury to your head or mouth? O Yes O No If yes, please explain: ______________________

Are you currently experiencing tooth or jaw pain? O Yes O No If yes, please explain: ______________________

Do you have any dental problems at this time? O Yes O No If yes, please explain: ______________________

Do you feel nervous about having dental treatment? O Yes O No If yes, please explain: ______________________

Are you happy with the appearance of your teeth and smile? O Yes O No If no, list your concerns: ______________________

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Please check all areas that you are interested in learning more about:

O Whitening O Veneers O Implants O Invisalign/clear aligners/braces O Partials/Dentures O Nightguards
O Athletic mouthguards O Smoothing/Shaping Chipped Teeth O Other: ______________________

Comments: ____

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Signature of patient, parent, or guardian:______________________________ Date: ____________